# Denials Management: From ADR to ADJ


*Presented by:*

**HARMONY UNIVERSITY**

*The Provider Unit of*

**Harmony Healthcare International, Inc.**

**HHI**



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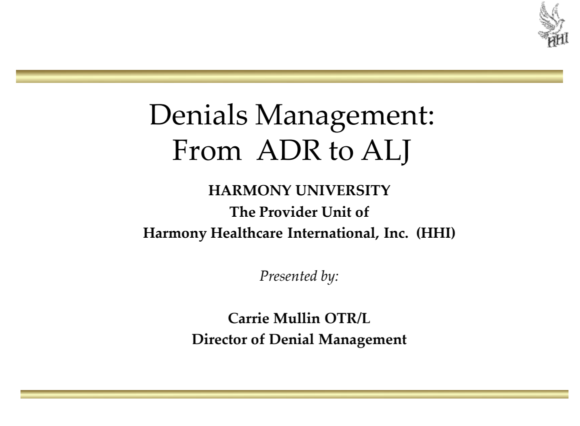


## Speaker Bio

- Director of Denial Services for Harmony Healthcare International, Inc. and Corporate Consultant for HHI since 2008
- MS OTR/L, RAC-CT
- Education:
  - Masters of Science in Occupational Therapy from Spalding University in Louisville, KY
  - Continuing Education in Contracture and Geriatric Therapeutic Exercise Courses
- Experience:
  - Senior Occupational Therapist and Director of Rehabilitation Services at Episcopal Senior Life Communities in Rochester, NY
  - Expert in Denials, Appeal letters, and prepping facilities for ALJ hearings

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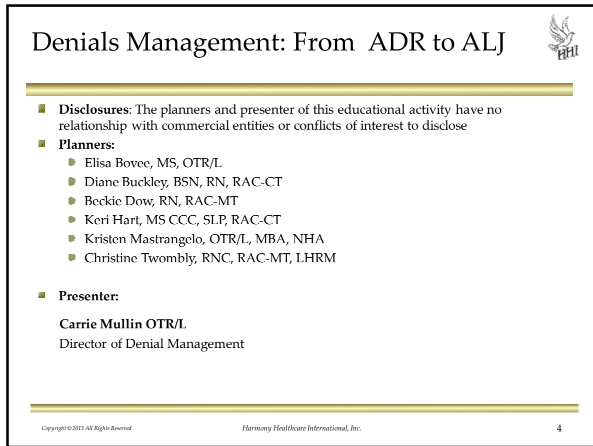


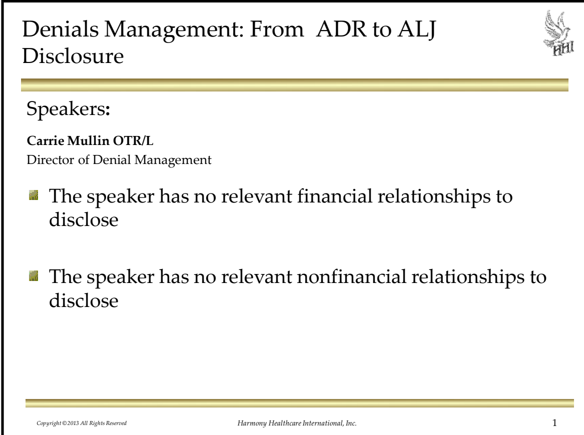


## Denials Management: From ADR to ALJ
## Criteria for Successful Completion

- Complete Sign-in and Sign-Out on Attendance Form
- Attendance for entire session
- Completion and submission of speaker Evaluation Form

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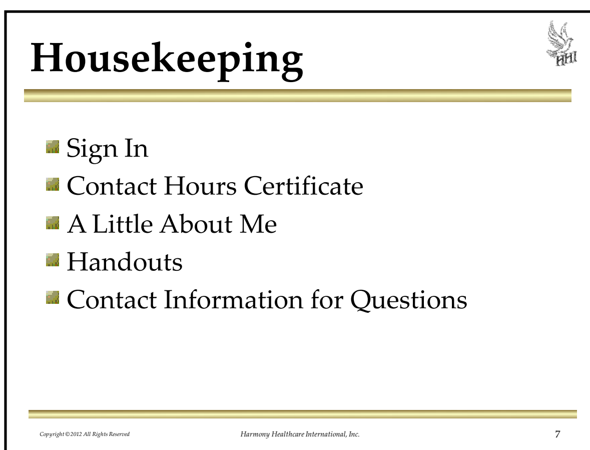


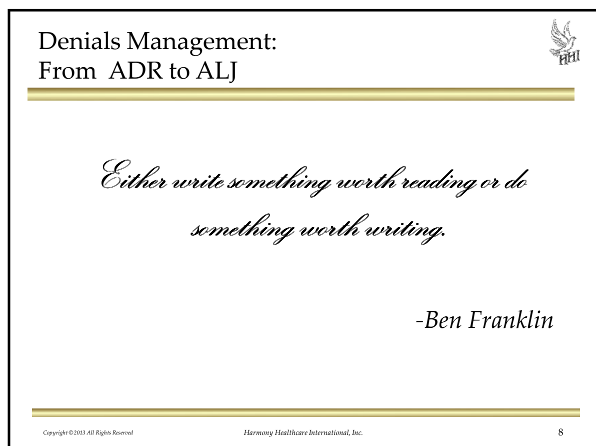


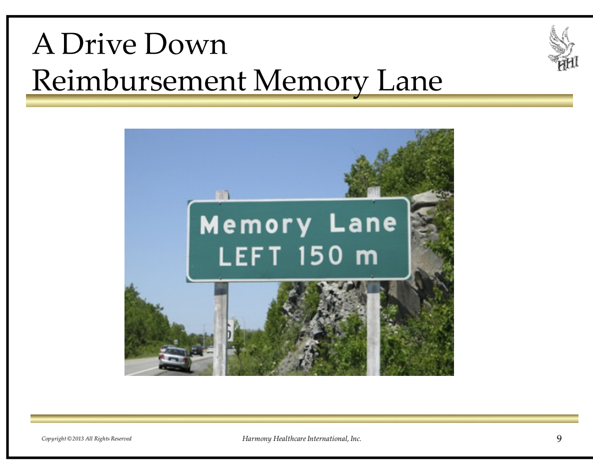


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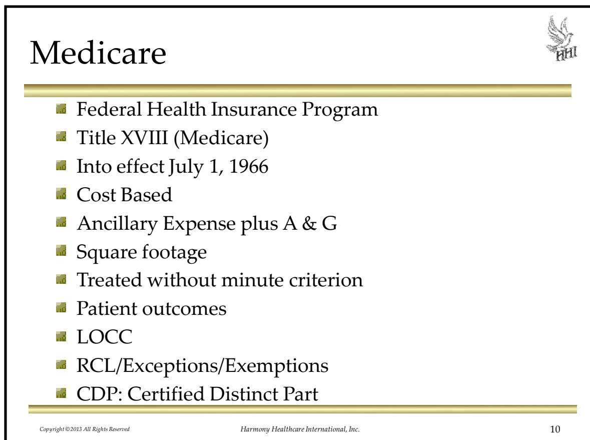


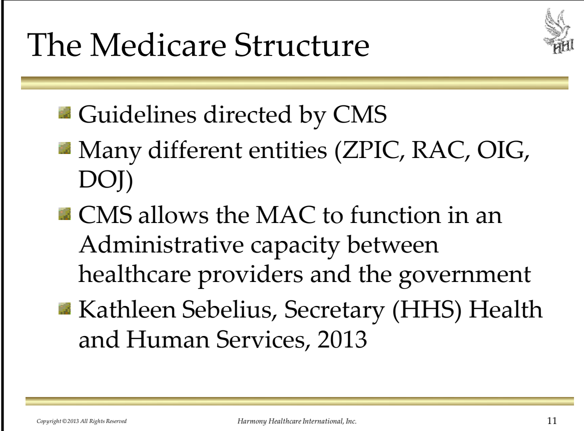


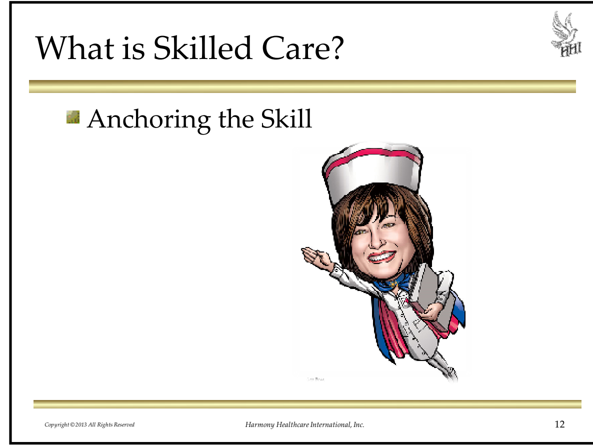


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## Medicare Requirements

- The patient requires **Skilled Nursing Services <u>or</u> Skilled Rehabilitation Services** (i.e., services that must be performed by or under the supervision of professional or technical personnel) (See §214.1 – 214.3)

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## Medicare Eligibility

Treated for a condition which was treated during a qualified stay…or… which arose while in a SNF for a treatment of condition for which the beneficiary previously was treated in a hospital

*For Example:*

Fractured hip develops pneumonia secondary to immobility

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## Medicare Requirements

- The patient requires these skilled services on a **daily basis** (see §214.5)
  - Daily Nursing Notes
  - Treatment Sheets

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## Federal Regulations

- Not always written clearly
- Not always written concisely
- Not always written definitively
- Do not always make logical sense
- Change on a regular basis!

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## Federal Regulations

- Medicare offers five levels in the Part A and Part B appeals process. The levels, listed in order, are:
  - Redetermination by a MAC
  - Reconsideration by a QIC
  - Hearing by an Administrative Law Judge (ALJ)
  - Review by the Medicare Appeals Council within the Departmental Appeals Board, (hereinafter "the Appeals Council")
  - Judicial review in U.S. District Court

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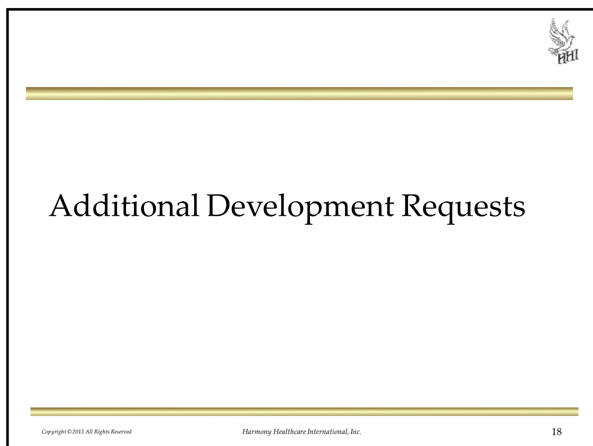


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## Additional Development Requests

- Medicare Contractors send providers additional development request (ADR) letters requesting additional documentation
- The ADR letters will be mailed and /or the claim in question will be in status location S B6001 that identifies claims in FISS that are in an ADR status/location

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## Additional Development Requests

- Do **not** submit replacement/duplicate claims for the ones pending in medical review
- The submission of replacement/duplicate claims will result in **claim denial**, rejection or recoupment and will
- This will p r o l o n g the medical review process

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## Additional Development Requests

- When the claim is finalized, the claim will have paid in full or part, or denied.
- If you disagree with the decision, you can request a redetermination/1st level of appeal within 120 days of the determination (date on the remittance advice).

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## Additional Development Requests

- After the 45th day, if the documentation needed to make a medical determination is not received, the claim may be denied as records not received timely and these claim denials are issued with Remittance Advice Code N102/56900

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## Additional Development Requests

- CMS guidelines allow contractors the time frame of 60 days to complete the review from the date on which the last of the requested medical records is received.

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## Harmony Healthcare International

**ADR Response**

**And**

**Appeal Packages**

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## The Appeal

- In order to effectively manage a Medicare denial, the facility must **work as a team** to gather pertinent information
- Assign a **team leader** to oversee the preparation of the denial package
- All members of the team should **review the medical record** to ensure completeness

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## The Appeal

- The following team members are beneficial in this process:
  - MDS Coordinator
  - Director of Nursing
    - Unit Managers (consider)
  - Restorative Nursing program Manager
  - Director of Therapy
    - Any therapy professionals involved in the patient's care
  - Social Services
  - Dietary
  - Additional team members who participated in care

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## The Appeal

- It is important to **read the ADR** or denial letter thoroughly as the letters will assist the facility in gathering the appropriate information
- Review the **list of items** provided in the decision statement to include in the medical record
  - Consider additional info not listed that will support the services provided

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## How Does Your Team Measure Up?

Take the Harmony Healthcare International (HHI) Denied Claims Appeals Process Proficiency Exam

http://cdn2.hubspot.net/hub/56632/file-285885026-pdf/DenialGraderWB.pdf

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## How Does Your Team Measure Up?

**1. To what degree does your facility have a monthly Triple Check system in place?**

a. The team meets every month to review UB-04s, MDS assessments, and Therapy Billing Logs
b. The team tries to meet each month, but sometimes it's hard to get the team together
c. The Billing Department double checks everything
d. There is no a Triple Check system in place

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## How Does Your Team Measure Up?

**2. ICD-9 codes on the UB-04 are determined using which of the following methods?**

a. The ICD-9 coding is updated monthly as the patient's skilled nursing and therapy needs change
b. The ICD-9 coding is determined shortly after the patient is admitted based on nursing and therapy needs
c. The ICD-9 coding is discussed by the team prior to end of month billing to ensure codes reflect the reason for hospitalization and skilled nursing needs
d. ICD-9 codes on the UB-04 are not a priority and likely do not reflect the patient's skilled needs

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## How Does Your Team Measure Up?

**3. Which item best represents how therapy evaluations support a decline in function?**

a. Therapy evaluations document a clear prior level of function and a significant decline from the patient's highest practicable level of function
b. Therapy evaluations document a clear prior level of function, but not all functional areas are tested on evaluation
c. Therapists are not always able to obtain a prior level of function or not all functional areas are tested on evaluation
d. Evaluations lack the details required to support a decline in function

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## How Does Your Team Measure Up?

**4. Accuracy on the Physician Certification Forms to reflect the skilled care provided by the Nursing and Therapy departments is achieved through which process below?**

a. Skilled qualifiers notated on the Certification forms are discussed as an interdisciplinary team and reflect the details of both nursing and therapy skilled services
b. Skilled qualifiers are pulled from the hospital discharge summary; therapy disciplines are also listed if the patient is evaluated per physician orders
c. Physician ordered therapies are listed on the form; the skilled nursing needs are only included if therapy is not involved
d. Physician Certification Forms are not in use

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## ADR/Help Letter Checklist

**HELP LETTER REVIEW CHECK LIST**

Period Skilled Nursing Chart Review: From: ________________ To: ________________

Medicare Admission Date: __________ Diagnosis: ____________________________

**MDS Reference Dates Review**

| | 5 day | 14 day | 30 day | 60 day | 90 day | SOT/EOT OMRA |
|---|---|---|---|---|---|---|
| ARD | | | | | | |
| Billing Dates | | | | | | |
| RUG/HIPPS | | | | | | |

| | COT | COT | COT | COT | COT | COT |
|---|---|---|---|---|---|---|
| ARD | | | | | | |
| Billing Dates | | | | | | |
| RUG/HIPPS | | | | | | |

**ICD-9 Codes**

______________________________________________________
______________________________________________________
______________________________________________________

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## The Appeal Package

- **List of items typically requested:**
  - Initial MDS and any MDS that corresponds to the billed dates of service and look back
  - All physician documentation for dates of service in question
    - Physician's orders
    - MD certifications
    - MD progress notes
    - History and Physical

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## The Appeal Package

- **Items to include**
  - Include all information in the medical record from the **look back period**
  - MD re-certifications for skilled stay for billed dates:
    - If certification is signed by a NP, be aware that there may be a request for the facility to submit an attestation letter verifying no direct or indirect employment relationship with the SNF

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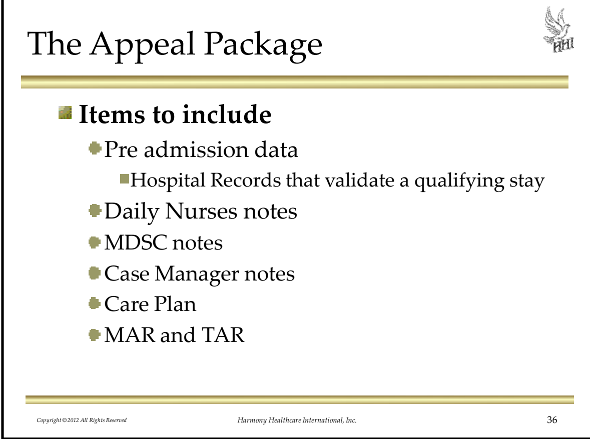


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## The Appeal Package

- **Items to include**
  - Documentation of all **therapies** provided
    - Evidence of MD supervision
    - Evaluations
    - Progress notes and
    - Therapy billing logs
  - Any other documentation that relates to the condition for which services were rendered that skilled the patient for Medicare Part A services in the Skilled Nursing Facility



## The Appeal Package

- **Items to include**
  - Diagnostic testing and lab work
  - Documentation of adjustment to HIPPS codes resulting from MDS corrections
  - Signature log for all staff members documenting in the medical record during the dates in question, including printed name, credentials and handwritten signatures



## The Appeal Package

- Important to know the consequences if the facility does not submit all necessary paperwork
  - Facility needs to review the packet carefully to avoid a **technical denial** based on missing information including signatures



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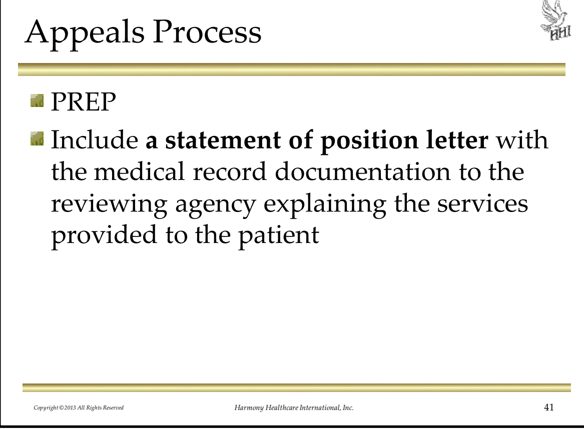
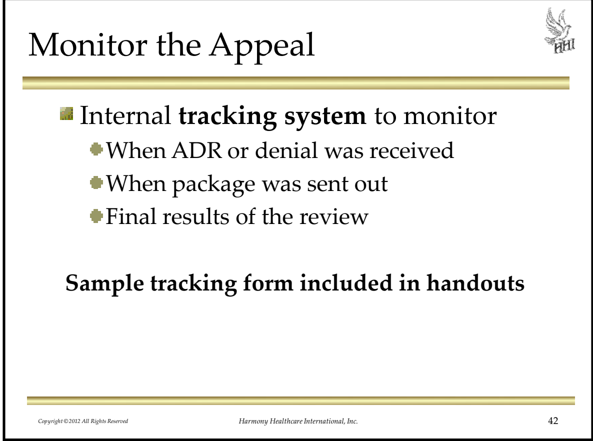
## The Appeal Package

- Each team member should review the package as a whole
- The team leader should have a final look prior to submitting the appeal
- PREP Letter
  - Proper Reimbursement Explanation Paper
- Always **keep a copy** of the packet sent to the reviewing agency

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## Monitor the Appeal

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## Technical Denial Reasons

- Response to Additional Documentation Request (ADR) did contain documentation requested
- Documentation not received within requested time frame
- Physician Certification not signed or missing
- Therapy Billing logs do not support billing
  - Part A – MDS Assessment
  - Part B - 8 Minute Rule
- Illegible documentation
- Hospital documentation was not submitted

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## Clinical Denial Reasons

- Documentation did not support **medical necessity**
- Documentation does not support **daily skilled intervention by a qualified therapist**
- Documentation in the medical records **must support continued progress**

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**Redetermination**
**and**
**Reconsideration**

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## Redetermination and Reconsideration

- If a claim is initially denied, there is action the facility can take
- The first stage is the **Redetermination**
- The next step is a **Reconsideration**

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## Redetermination

- An examination of a claim by a review agency who is different from the agency who made the initial determination
- The facility has **120 days** from the date of receipt of the initial claim determination to file an appeal
- A minimum monetary threshold is not required to request a determination

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## Redetermination

- Request for redetermination may be filled on Form CMS-20027 available at http://www.cms.hhs.gov/CMSForms/CMSForms/list.asp#TopOfPage

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## Redetermination

- Requests not made on Form CMS-20027 must include:
  - Beneficiary name
  - Medicare Health Insurance Claim (HIC) number
  - Specific service and/or items(s) for which a redetermination is being requested.
  - Specific date(s) of service

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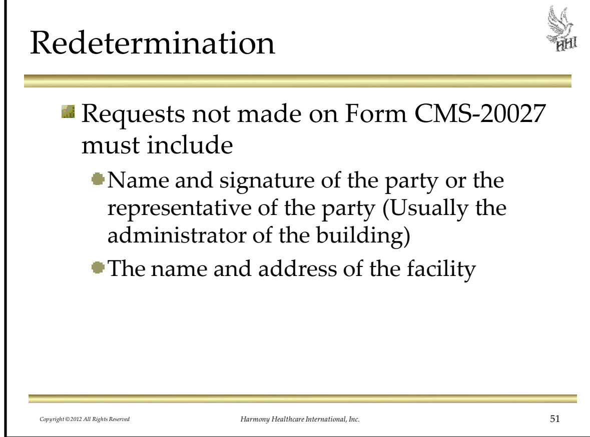


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## Redetermination

- Include an **appeal letter** that outlines the argument for coverage
  - Brief explanation of the hospitalization (if one occurred)
  - Past medical history
  - Status of patient on admission
  - List of the skilled nursing services provided to the patient

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## Redetermination

- Appeal Letter
  - An explanation of skilled therapy services provided to the patient
  - Medicare guidelines used in the skilled care decision making process, if applicable

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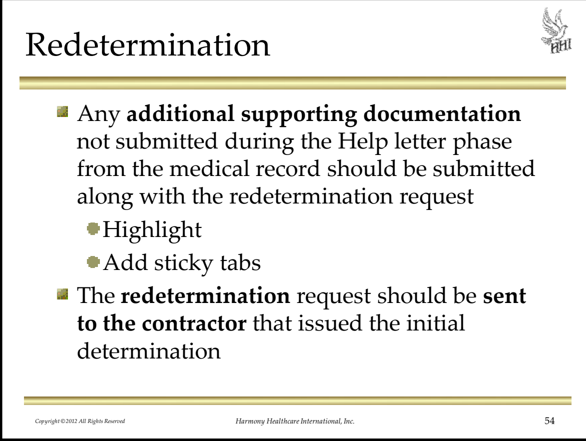


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## Redetermination

- Contractors will generally issue a decision within 60 days of receipt of redetermination request in the form of :
  - A letter
  - A Medicare Redetermination Notice (MRN)
  - Revised remittance advice



## Reconsideration

- If the request for redetermination results in a denial, a **reconsideration** can be requested
- A **QIC** will conduct the reconsideration request
- The QIC reconsideration process allows for an independent review of medical necessity by a panel of physicians or other health-care professions
- A minimum monetary threshold is not required to request a reconsideration



## Reconsideration

- A written reconsideration request must be filed within **180 days** of receipt of the redetermination
- Instructions are provided on the Medicare Redetermination Notice (MRN)
- A Request for reconsideration may be made on Form CMS-20033. This form will be mailed with the MRN



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## Reconsideration

- If Form 20033 is not used, request must contain:
  - Beneficiary name
  - Medicare Health Insurance Claim (HIC) number
  - Specific service(s) and/or item(s) for which the reconsideration is requested
  - Specific date(s) of service



## Reconsideration

- Documents to include
  - Name and signature of the party or the representative of the party (usually the administrator of the building)
  - Name of the contractor that made the determination
  - Name and address of the facility



## Reconsideration

- Include a letter outlining the argument for payment
  - Brief explanation of the hospitalization (if one occurred)
  - Past medical history
  - Status of patient on admission
  - List of skilled nursing services provided to patient
  - Explanation of skilled therapy services provided
  - Medicare guidelines used in skilled care decision- making process, if applicable



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## Reconsideration

- The request should clearly explain why the facility disagrees with the redetermination
- A copy of the MRN, and any other supportive documentation, should be sent with the reconsideration request to the QIC identified in the MRN

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## Reconsideration

- If facility submits documentation after the reconsideration request has been filed, the QIC can extend the time they have to make their decision
- Additionally, any evidence noted in the redetermination as missing and any other evidence relevant to the appeal, must be submitted prior to the issuance of the reconsideration decision

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## Reconsideration

- Evidence not submitted at the reconsideration level may be excluded from consideration as subsequent levels of appeal unless you show good cause for submitting the evidence late

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## Reconsideration

- Reconsiderations are conducted on-the-record; and in most cases, the QIC will send its decision to all parties within 60 days of receipt of the request for reconsideration
- The decision will contain detailed info on further appeal rights if the decision is not fully favorable

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## Reconsideration

- If the QIC cannot complete its decision in the applicable timeframe, it will inform the appellant of their right to escalate the case to an ALJ

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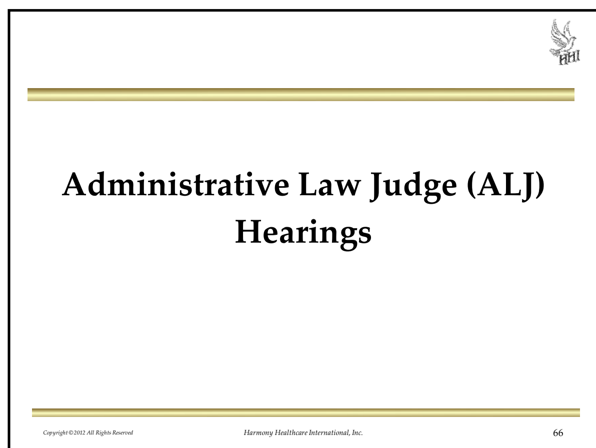


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## ALJ Overview

- After the redetermination and reconsideration process, if at least **$130 remains** in controversy following the QIC's decision, the facility may request an **ALJ hearing** within 60 days of receipt of the reconsideration
- The facility must send a notice of the ALJ hearing request to the QIC on the hearing request form or in the written request

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## ALJ Overview

- A letter to request the ALJ hearing should simply highlight the most pertinent reasons justifying payment

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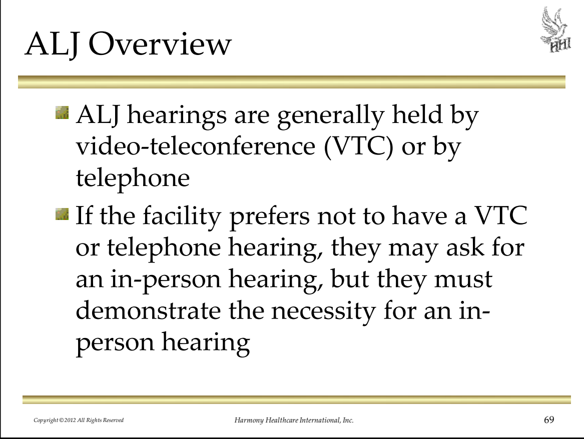


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## ALJ Overview

- The ALJ will determine whether an in-person hearing is warranted on a case-by-case basis
- Facilities may also ask the ALJ to make a decision without a hearing (on-the-record).
- CMS or its contractors may participate in an ALJ hearing, but they must provide notice to the ALJ and all parties of the hearing



## ALJ Overview

- ALJ will generally issue a decision within 90 days of receipt of the hearing request
- The timeframe may be extended for a variety of reasons including, but not limited to:
  - The case being escalated from the reconsideration level
  - The submission of additional evidence not included with the hearing request
  - The request for an in-person hearing
  - The facility's failure to send notice of the hearing request to other parties and
  - The initiation of discovery if CMS is a party



## ALJ Overview

- If the ALJ does not issue a decision within the applicable timeframe, you may ask the ALJ to escalate the case to the Appeals Council level



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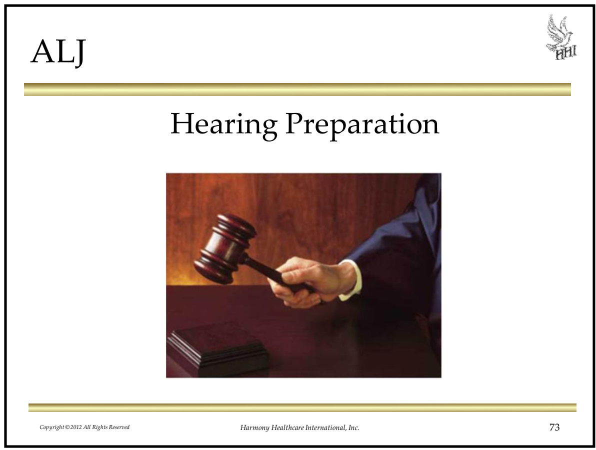


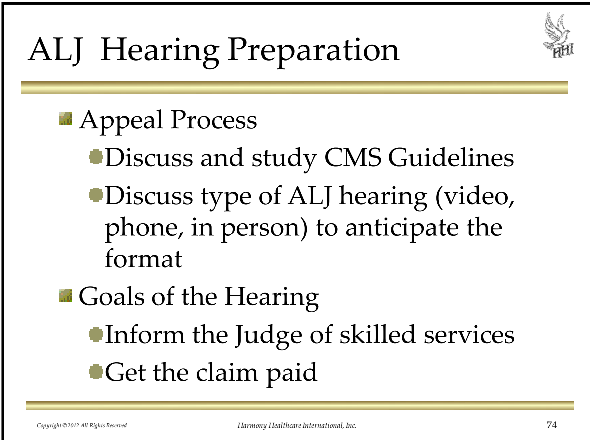


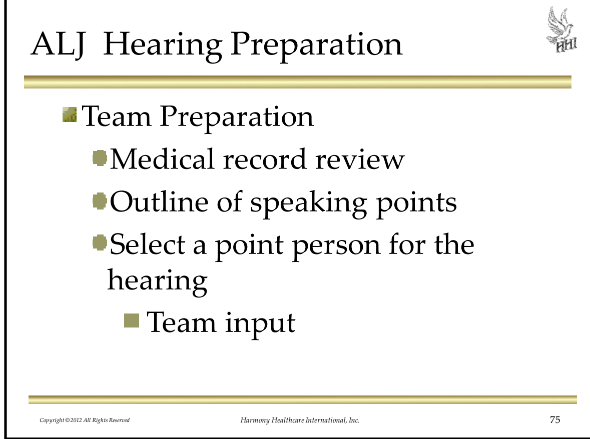


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## ALJ Hearing

- Hearing Process
  - Prepare the facility designated hearing room for video or phone hearings
  - Judge's assistant will initiate the phone contact (test phone lines and speakers)
  - Introductions
  - Statement by facility
  - Offer to fax any pertinent documents discussed during the hearing

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## ALJ Hearing

- Organize documentation
- Keep pertinent notes or forms at your finger tips
- Number the pages for reference
- Have the staff that worked with patient on the call
- Speak respectfully, clearly, slowly
- Provide a concise summary

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## ALJ Hearing

- Be prepared to answer questions prepared by the Judge
  - Why did the patient require skilled therapy when they were hospitalized for a UTI?
  - Where does the medical record state that continued therapy services were necessary after the initial date in question?
  - Explain why skilled care continued although the notes indicate the patient did not have an exacerbation of medical condition?

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## ALJ Hearing

- Be prepared to answer questions asked by the Judge
  - When did the patient get discharged from therapy services?
  - Why do the daily nursing notes state the patient was ambulating ad lib, yet physical therapy continued to provide skilled treatment?



## Appeal Rights

## Appeal Rights

- Right to Appeal:
  - If the Beneficiaries is the only one with the right to appeal given specific situations, provider must obtain transfer from beneficiary
  - Beneficiaries may transfer appeal rights to providers who provide the items or services and do not otherwise have appeal rights
  - Form CMS-20031 must be completed and signed by the beneficiary and supplier to transfer the beneficiary's appeal rights



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## Appeal Rights

- Right to Appeal
  - All appeal requests must be made in writing



## Appeal Rights

- Medicare offers five levels in the Part A and Part B Appeals Process:
  1. Redetermination by a MAC
  2. Reconsideration by a QIC
  3. Hearing by an Administrative Law Judge (ALJ)
  4. Review by the Medicare Appeals Council, within the Department Appeals Board
  5. Judicial review in U.S. District Court



## Appeal Rights

- **Redetermination**
  - A review of the claim by the MAC utilizing personnel who are different from the personnel who made the initial determination
  - The appellant (individual filing the appeal) has 120 days from the date of receipt of initial denial to file an appeal
  - A minimum monetary threshold is not required to request a redetermination



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## Appeal Rights

- **Reconsideration**
  - If the facility is **dissatisfied** with result of redetermination, they may request a **reconsideration**
  - A Qualified Independent Contractor (QIC) will conduct the reconsideration
  - The reconsideration process is an independent review of medical necessity by a panel of physicians or other health care professionals
  - A minimum monetary threshold is not required to request a reconsideration



## Appeal Rights

- **ALJ Hearing**
  - If at least $130 remains in controversy following the QIC's decision, the facility may request an ALJ hearing within 60 days of receipt of the reconsideration
  - The facility must also send a notice of the ALJ hearing request to the QIC and verify this on the hearing request form or in the written request



## Appeal Rights

- **Medicare Appeals Council Review**
  - If the facility is dissatisfied with the ALJ's decision, may request review by Medicare Appeals Council
  - No requirements regarding the amount of money in controversy
  - The request must be submitted in writing within 60 days of receipt of ALJ's decision and must specify the issues and findings that are being contested



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## Appeal Rights

- **Medicare Appeals Council Review**
  - Generally, the Appeals Council will issue a decision within 90 days of receipt of a request. Timeframe may be extended for various reasons, such as the case being escalated from an ALJ hearing
  - If a decision is not issued within timeframe, facility may ask the Appeals Council to escalate the case to the Judicial Review level

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## Appeal Rights

- **Medicare Appeals Council Review**
  - If at least $1,260 or more is still in controversy following the decision, the facility may request judicial review before a U.S. District Court Judge
  - Appellant must file request for review within 60 days of receipt of the Appeals Council's decision

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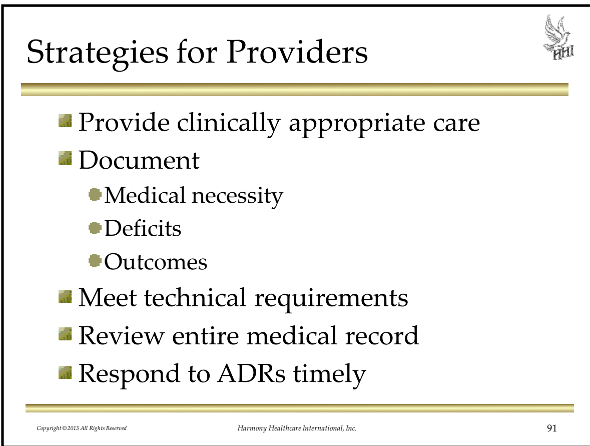


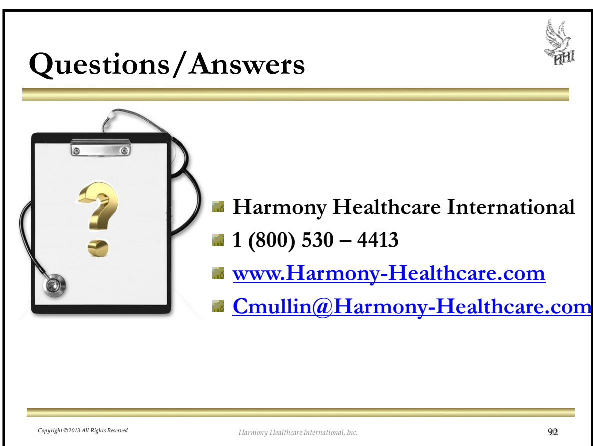

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