

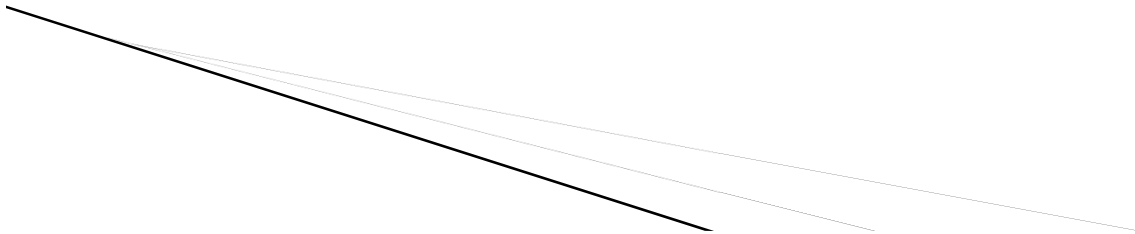
100 Ways to Prevent an Overpayment

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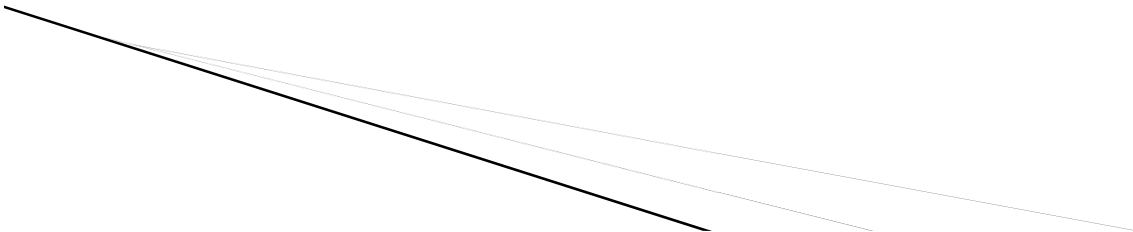
Learning Objectives

- ▶ Common Medicare Billing Mistakes
- ▶ Systems and protocols necessary to help prevent and overpayment
- ▶ Best practices in resolving an overpayment



Regulatory Framework

- ▶ Social Security Act
- ▶ Code of Federal Regulations
- ▶ CMS Claims processing Manual
- ▶ NUBC Billing Guide
- ▶ Fiscal Intermediary Directions

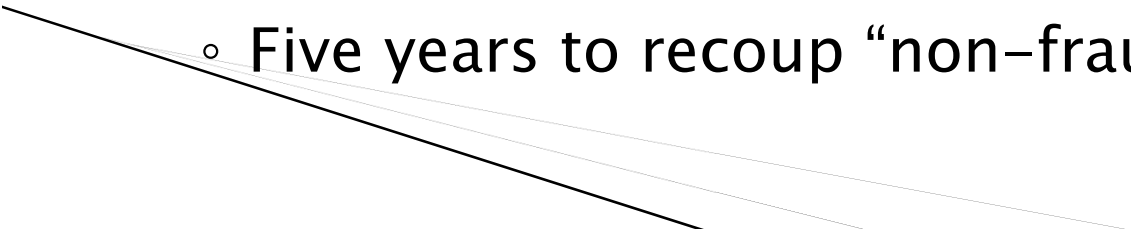


Recent Changes

▶ Proposed Rule

- Medicare Program – Reporting and Returning of Overpayments
- Federal Register
 - 77 Fed. Reg. 9179–9187 (Feb. 16, 2012)
- Final rule has not yet been published

▶ Fiscal Cliff Deal

- Five years to recoup “non-fraudulent” overpayment
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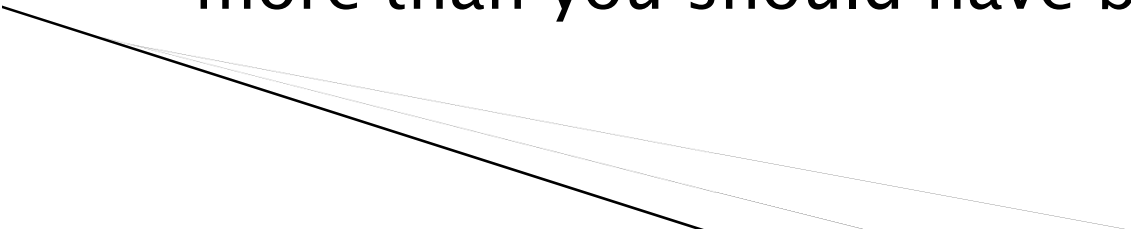
Overpayment Defined

- ▶ Proposed Rule

- ▶ Section 1128(d) of the Act

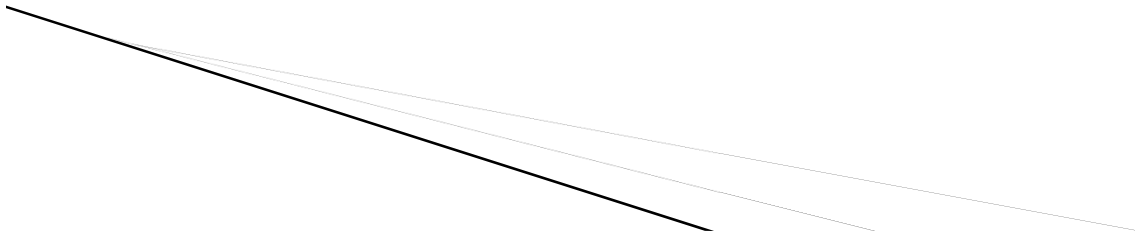
“...any funds that a person received or retains under title XVIII...to which the person, after applicable reconciliation, is not entitled under such title.”

- ▶ An overpayment occurs when Medicare pays you more than you should have been paid.

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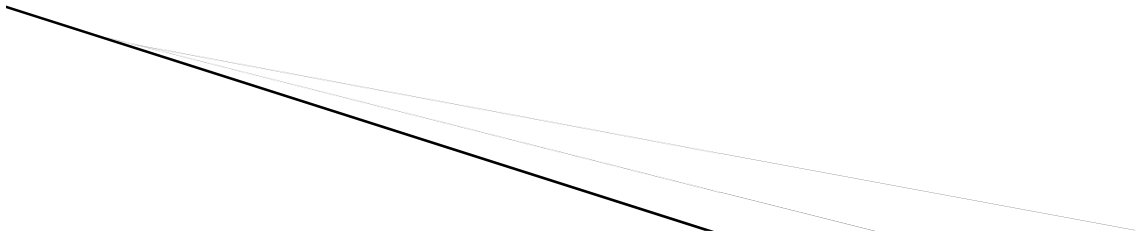
Overpayment Examples

- ▶ Medicare payment for non-covered services
- ▶ Medicare payment in excess of the amount allowable
- ▶ Errors and non-reimbursable expenditures in cost reports
- ▶ Incorrect coding resulting in higher reimbursement
- ▶ Payments for services by an unlicensed or excluded individual
- ▶ Duplicate payment
- ▶ Medicare should have been secondary



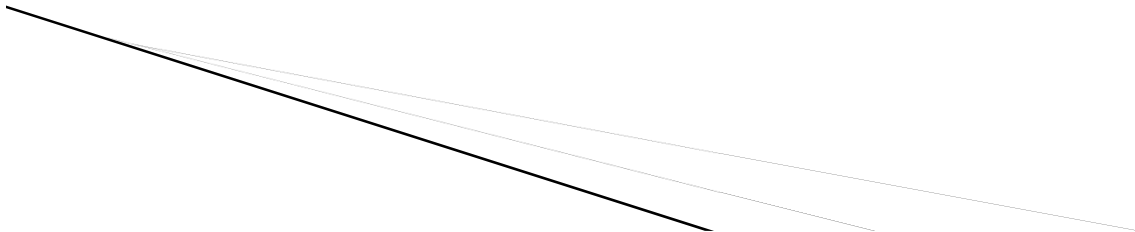
Discovery of an Overpayment

- ▶ Common ways a overpayment may be discovered
 - Compliance plan – systematic audit
 - Fiscal Intermediary
 - Employee reported
 - ZPIC
 - RAC

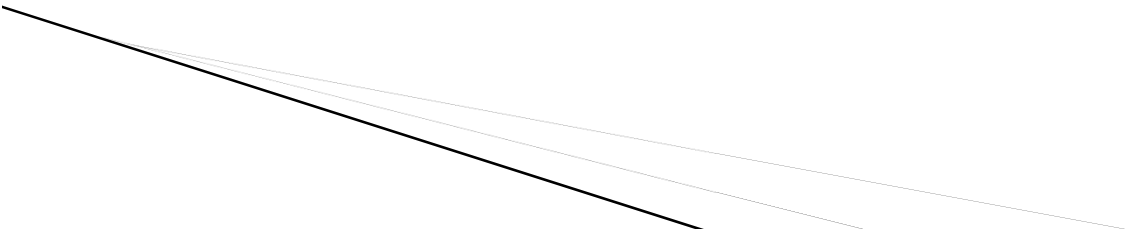


Where does an Overpayment Start?

- ▶ Submission of UB-04 or 1500 [Medicare Claim]
 - Whether by paper or electronic means
- ▶ The Medicare cost report
 - More complex
 - Since nursing homes are paid prospectively
 - Only requests for reimbursement of bad debt generate an overpayment
 - However
 - Cost claimed in excess of what is allowable also creates a problem



UB04: Source of Overpayment

- ▶ Conditions of Participation
 - CMS Form 855A
 - ▶ Eligibility
 - Qualifying Hospital Stay
 - Benefit Period
 - Physician Certification
 - Condition treated or arose as part of hospital stay
 - ▶ Facility Census
 - ▶ Charge Master
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UB04: Source of Overpayment

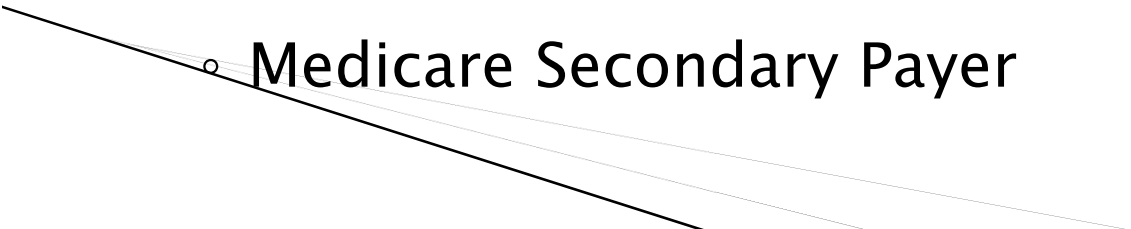
▶ Clinical Record

- Admission Information
- MDS – RUGS, Assessments Dates
- Diagnosis Coding / Sequencing
- Incident Reporting

▶ Clinical Record [Documentation]

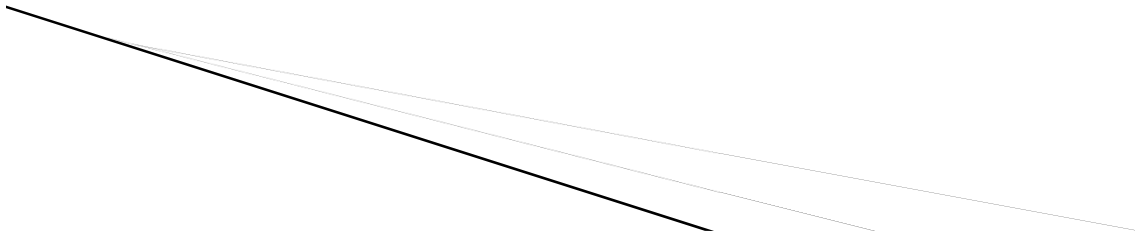
- ADL
 - Isolation
- 

UB04: Source of Overpayment

- ▶ Clinical Record [Therapy]
 - Minutes/Visits on MDS
 - Minutes / Units
 - Functional Outcome Modifiers
 - ▶ Financial Folder
 - Identity Check
 - Correct Health Information
 - Medicare Secondary Payer
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Five Necessary Audits

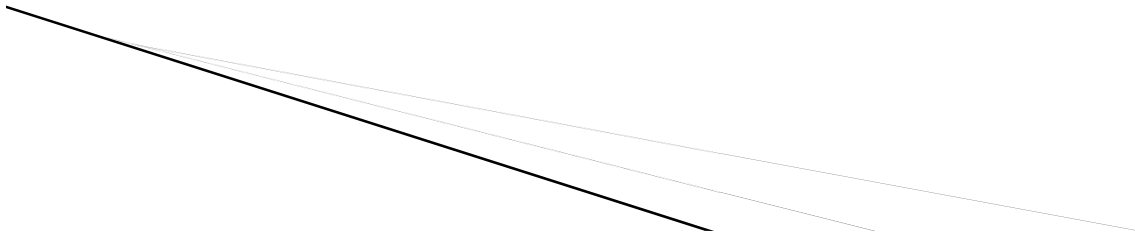
1. Eligibility Review
2. MDS Review
3. Therapy Review
4. Financial Folder Audit
5. Claim Triple Check



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Eligibility Review

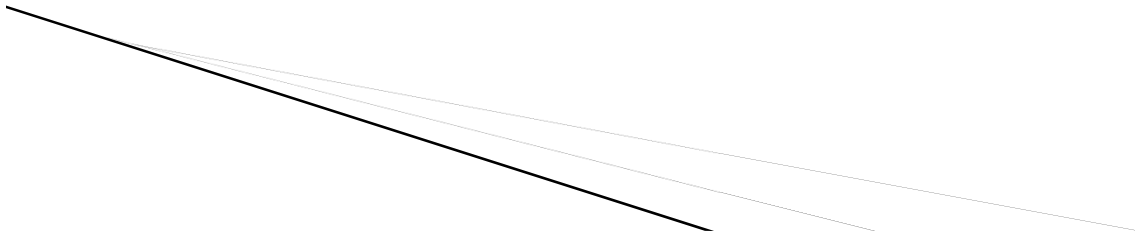
- ▶ Medicare Meeting
 - Venue to discuss resident eligibility for services
- ▶ Entitlement
 - Part A coverage
 - Part B coverage
- ▶ Eligibility – Part A
 - days available
 - 3 midnight stay
 - Physician Certification
 - Services related to hospital stay



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Eligibility Review

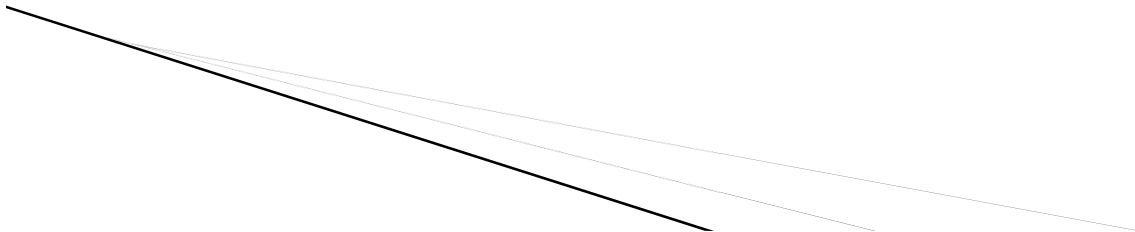
- ▶ Eligibility – Part B
 - Services require therapy skill
 - Services related to clinical diagnosis
 - Is this supported by nursing documentation
 - Has therapy CAP been reached



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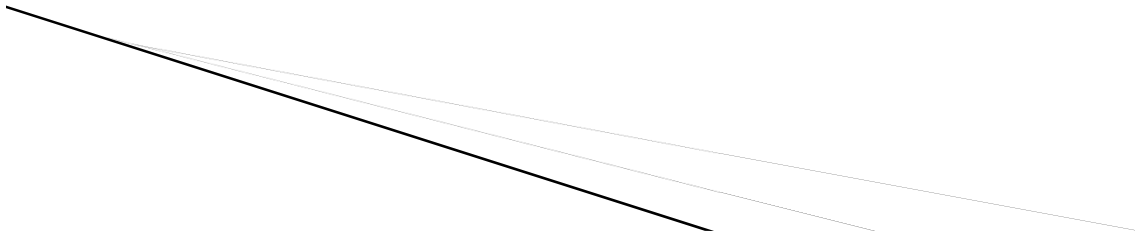
MDS Review Process

- ▶ Purpose is to assure that ALL required MDSs are completed timely and accurately
- ▶ MDS Completed
- ▶ Unscheduled Review
 - COT
 - EOT; EOT/R
- ▶ Participation:
 - MDS Coordinator
 - Therapy
 - Business Office



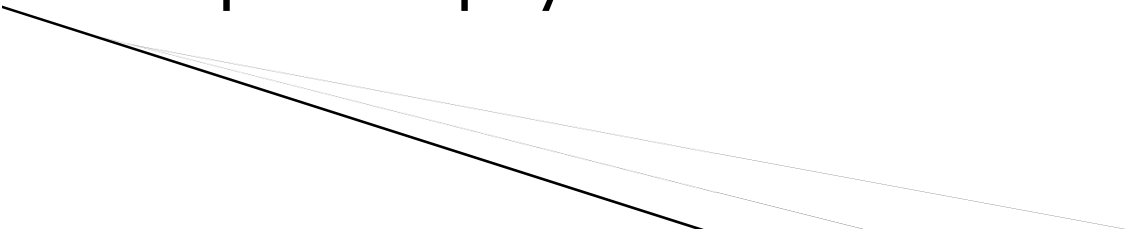
System of Prevention Therapy Review

- ▶ Part A
 - Certification – POC
 - Therapy Minutes/Visits
 - Diagnosis
- ▶ Part B
 - HCPCs codes
 - Time Codes – calculating units
 - Functional Reporting: G Codes
 - Therapy Review – CAP



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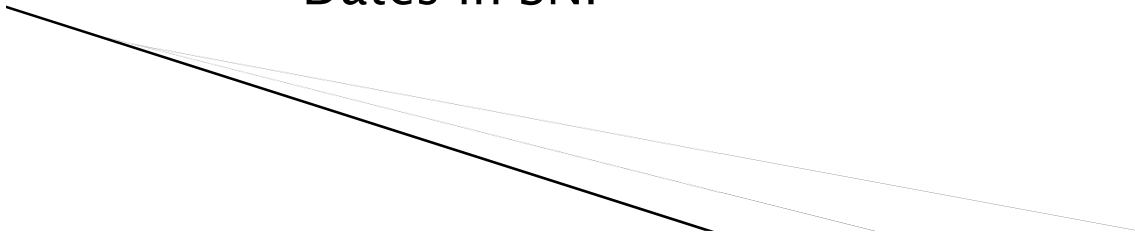
Financial Folder Audit

- ▶ Too often the business office does not adequately maintain a financial folder pertaining to each resident.
 - ▶ Maintaining a central source of information relating to each resident is necessary to assure claims are submitted correctly AND
 - ▶ An organized source of information leads to quicker payment and lower accounts receivable
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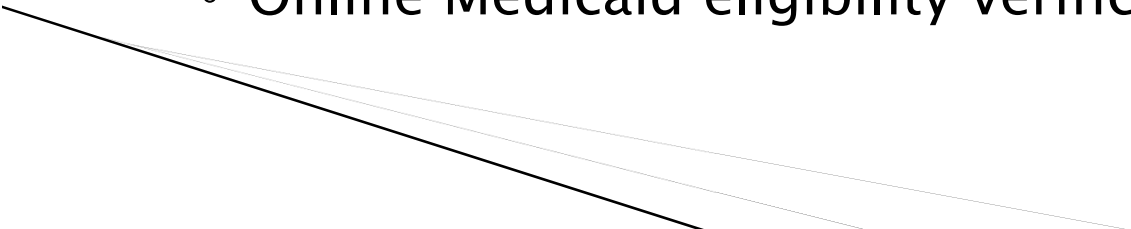
Financial Folder Audit

- ▶ Financial Folder audit Checklist [Admission]
 - Signed Admission agreement
 - Medicare Secondary Payer Questionnaire
 - Power of Attorney [POA]
 - REP Payee Information
 - Assignment of Benefits From [AOB]
 - Prior stay information
 - Dates in Hospital
 - Dates in SNF



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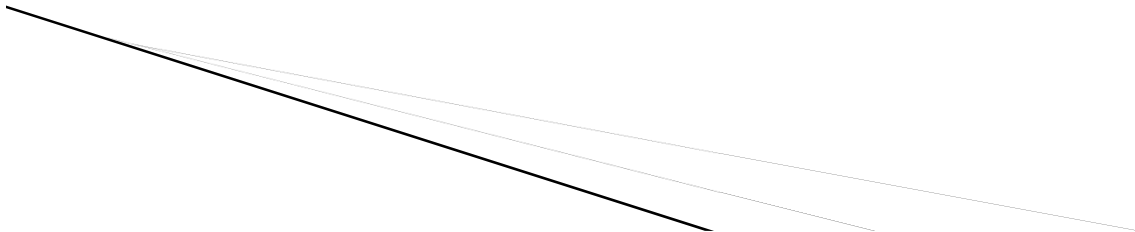
Financial Folder Audit

- ▶ Financial Folder audit Checklist [Billing]
 - Copy of Identification [DL, Passport, Other]
 - Medicare card
 - Other insurance cards
 - Common Working File Printout
 - Insurance Authorizations
 - Medicaid notification to state if applicable
 - Medicaid award letter if applicable
 - Online Medicaid eligibility verification
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Financial Folder Audit

- ▶ Financial Folder audit Checklist [Payment]
 - Remittance Advice from insurance company
 - MSP amounts paid
 - Collection letters and collection notes
 - Medicare bad debt log



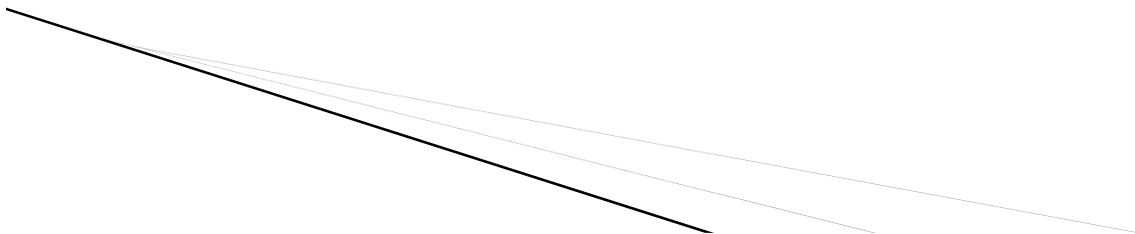
Systems of Prevention

Triple Check – UB04 Review

The purpose of triple is to assure the Medicare claim correctly reflects the care provided to the resident and that all items on the claim are supporting by various records maintained at the facility.

Triple check is not the time to audit underlying systems and reports [e.g. therapy minutes, ADL coding] those items should be audited through independent processes.

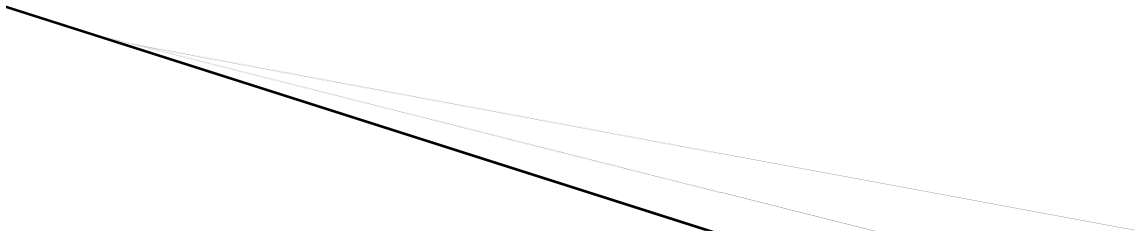
Triple check is the final system check against the UB–04



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Triple Check – UB04 Review

- ▶ The players
 - MDS Coordinator
 - Medicare Nurse
 - Business Office Manager
- ▶ Source documents
 - Graphic census
 - Face sheet
 - Completed MDSs
 - Financial Folder

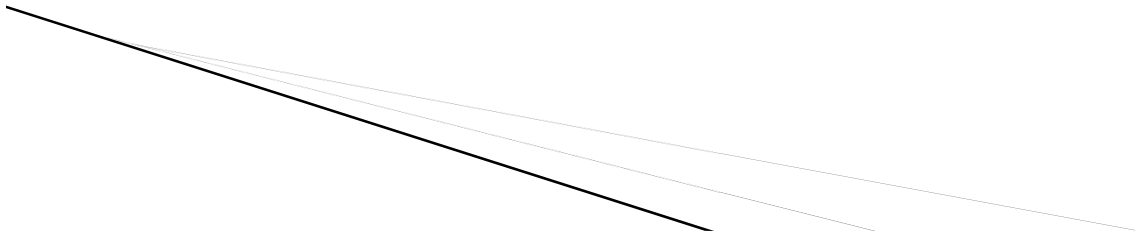


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Triple Check – UB04 Review

▶ Preparation

- Prior to Triple Check the MDS reviews should be completed and each MDS should be transmitted and ACCEPTED.
- Prior to Triple Check the Therapy logs should have been reviewed by the rehab manager and certified as accurate
- Prior to Triple Check the Financial Folders should be reviewed and accurate



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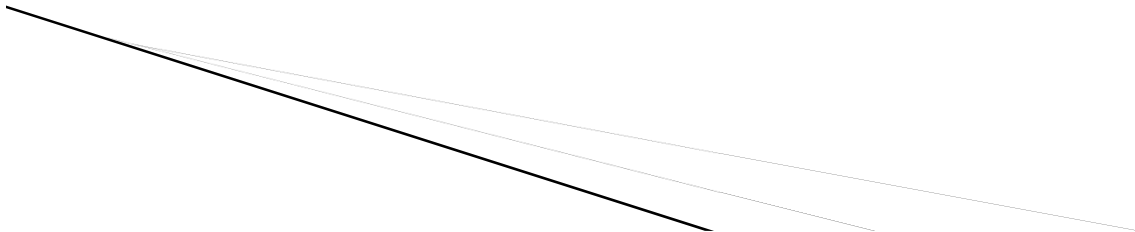
Triple Check

▶ Census

- Admission and discharge dated or accurate
- Type of bill [TOB] is appropriate
- Leave of absence is entered if required
- Revenue codes and days are entered correctly

▶ Charge Master

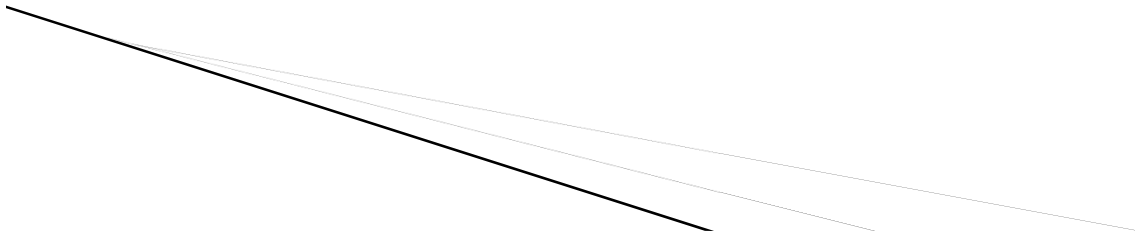
- Posted room rate
- Ancillary charges



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Triple Check

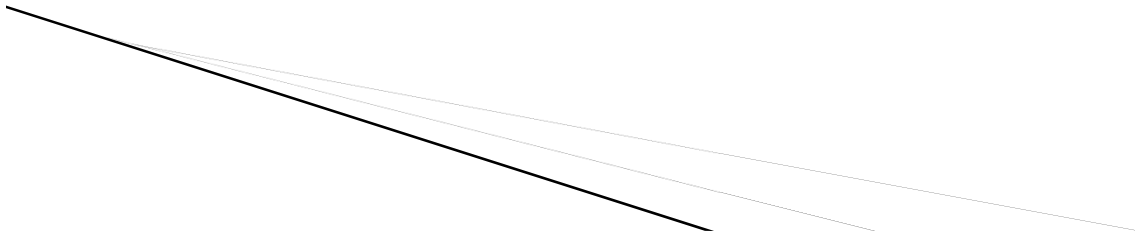
- ▶ Admission Information
 - Occurrence codes / significant events
 - Prior Hospital Stay [Inpatient days]
 - Primary reason for admission
 - Reason for admission [Accident]



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Triple Check

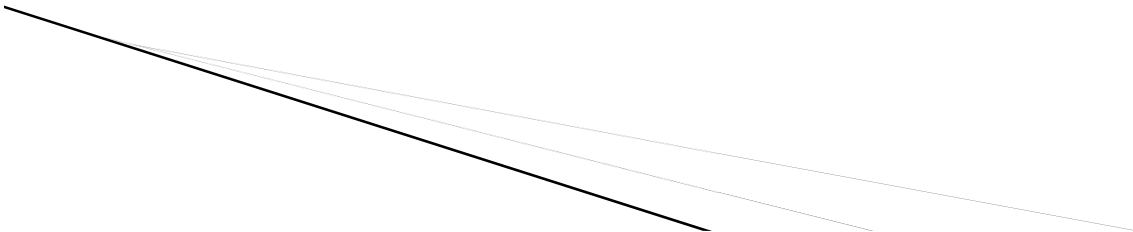
- ▶ MDS – Review Process
 - All MDS are on UB-04
 - A3a matches
 - HIPPS matches
 - Verify timing against MDS calendar



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Triple Check

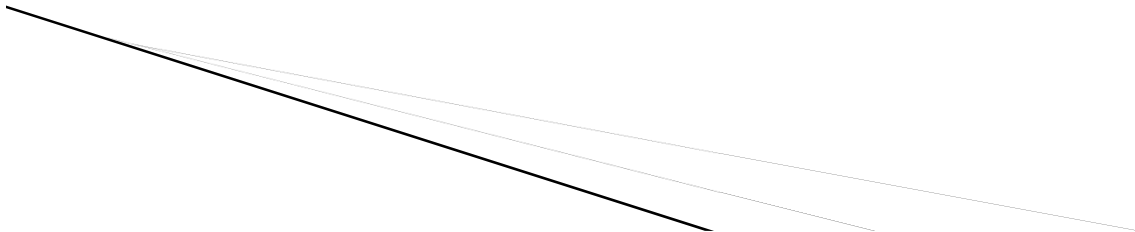
- ▶ Therapy Review
 - Therapy Visits / Minutes
 - Therapy Cap
 - Functional Outcome Modifiers



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Triple Check

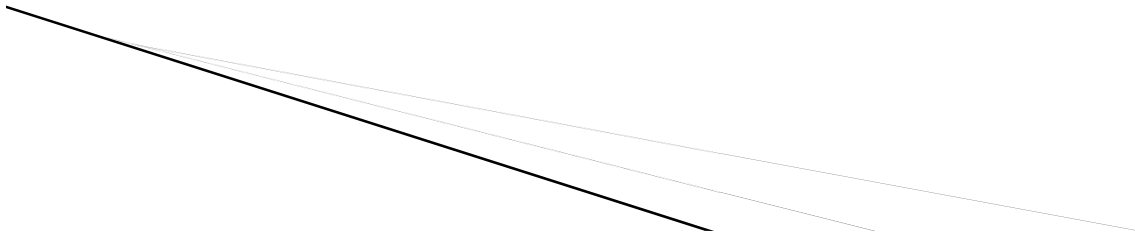
- ▶ Diagnosis Coding
 - Diagnosis are all included
 - Correctly sequenced
- ▶ Coding should be completed to the 5 digit when appropriate
- ▶ It is not appropriate for the biller to change diagnosis codes from what is officially reported in the medical record
- ▶ It is just as wrong to exclude a necessary Dx code as it is to include one that is incorrect



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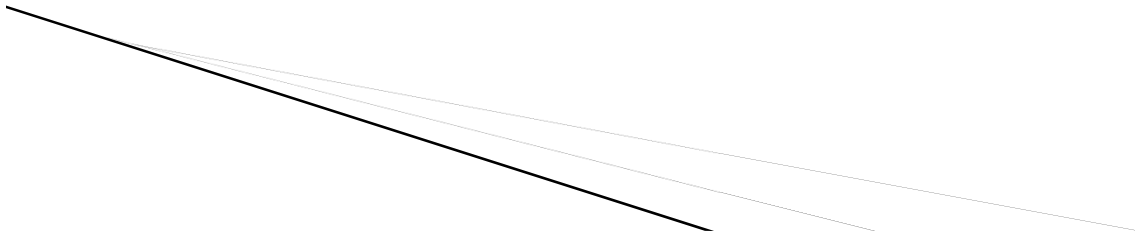
Triple Check

- ▶ Financial Folder
 - Medicare number match
 - DOB matches
 - AOB on file
 - Insured information correct
 - Medicare correctly billed as primary
 - Notice of non-coverage

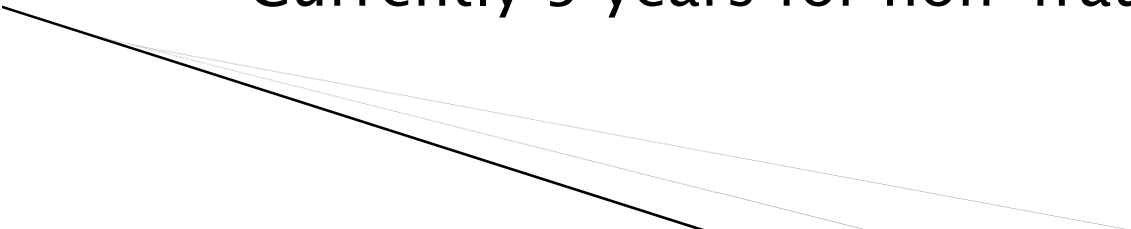


Resolving an Overpayment

- ▶ Initial questions
 - Was the overpayment intentional?
 - What are the dates of service?
 - Was the overpayment systematic?
 - When & How was the overpayment discovered?
- ▶ Options
 - Call your healthcare lawyer
 - Talk to your Mac
 - Submit corrected claims
 - Follow the formal process



Repayment

- ▶ The 60 day rule
 - In effect since March 23, 2010
 - From date overpayment is identified or,
 - Date any corresponding cost report is due
 - Does not apply to overpayments generated by submission of UB-04 in fee based environment
 - ▶ Identified
 - Actual knowledge of overpayment or,
 - Reckless disregard or deliberate ignorance
 - ▶ Look back period
 - Currently 5 years for non-fraudulent claims
- 

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