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LIMITLESS

2023 ANNUAL CONFERENCE

MAY 17-19, 2023

We-Ko-Pa Conference Center • Scottsdale, Arizona

ArizonaLeadingAge.org

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AGENDA

Charting an “Advantage” Course

Prepare + Share

Medicare Skilling Criteria – The essential ingredient

Claim Prep = Payment

Defining the Roles of the Team

ADR and Appeal Preparations

Successful Outcomes

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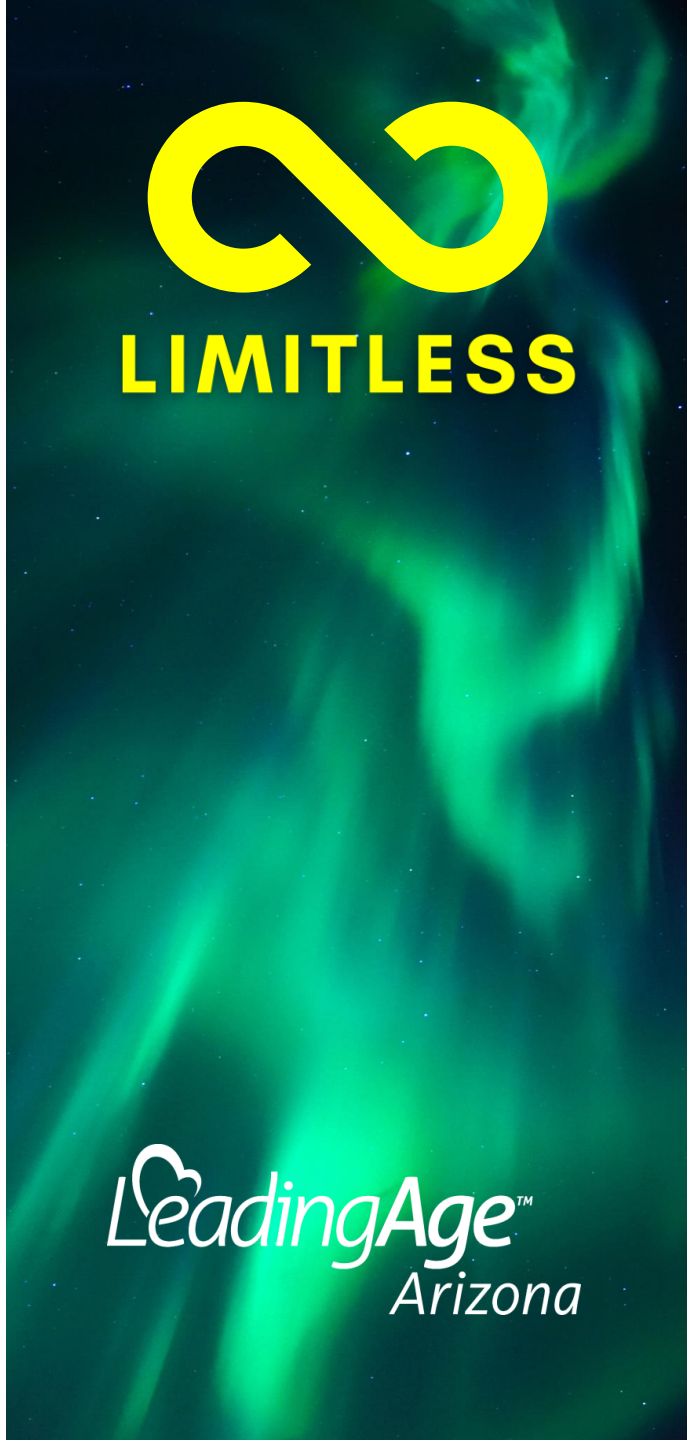
Charting an "Advantage Course"



Some markets are over 70% managed...and growing

Terms and Agreements vary with each product

Is there opportunity to drive rates

Agreement contents; team awareness

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Paving the Road Ahead

Product Drivers

MA Partners “Must haves

5 Star Rating
Quality Reporting; Outcomes
LOS
Acuity; HCC Rating

Out of Network

Is this an option? How do rates differ? If referral #’s are similar, may be a better course of action

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MEDICARE ADVANTAGE STRIKES AGAIN

New Star Rating Methodology for MA

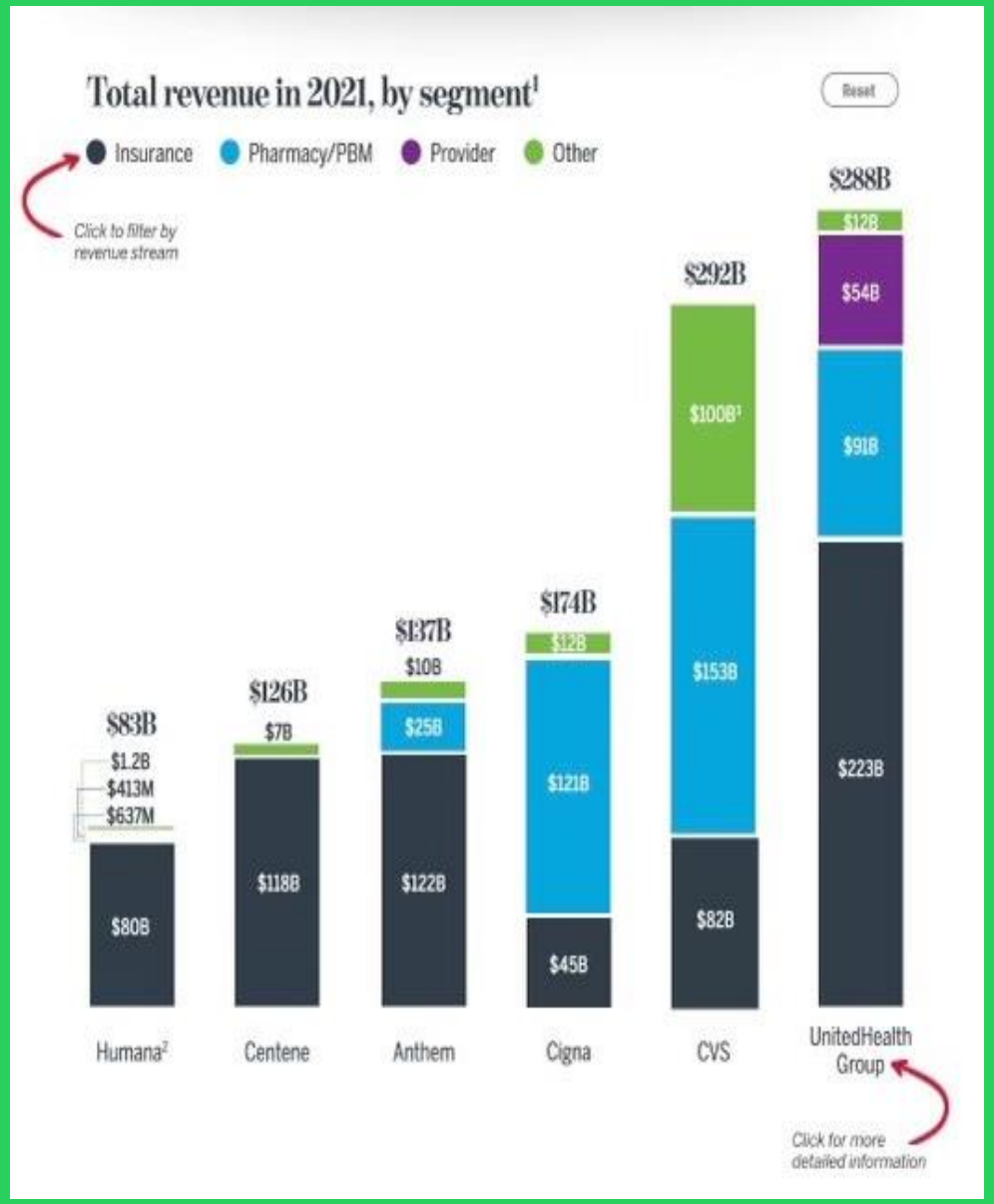
4.37 Stars Avg wt	Unprecedented improvement in MA Stars for 2022 with CMS method
30-40%	Temp changes due to COVID implemented by CMS
Disaster provisions + cut points	2023 and 2024 could see half of “plans” with reduced ratings

Diversification of Health Insurers

In the midst of headwinds, Health Insurers have pursued service expansion.

Expansion of business segments results in expansion of revenue streams.

Per Advisory Board these traditional insurers are becoming, “diversified health solutions companies.”



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Advisory Board

An Arrow into A Flower

Key Concepts that Will Define our Perception

Obstacles don’t have to be the enemy

Reframe and view as a mentor

What can we learn?

Tor-mentor – leading to getting unstuck

OPPORTUNITIES TO MEET CONSUMER WANTS + NEEDS

Discovery series on the differences

Invite beneficiaries and families to come and ask questions

Leverage internal and real time data to connect and negotiate better rates

Monitor your market for Payor Innovation and Shared Savings opportunities

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The Power of Predictive Analytics

PROFILITY

Patient Prediction

General:

Prediction Subject	Current	Potential
ADL Improvement	Limited assistance	High
Walking Improvement	Limited assistance	High
Independent ADL	Limited assistance	Very High
Independent Walking	Limited assistance	High
Independent Transfer	Limited assistance	Very High

General:

Prediction Subject	Current	Risk
Readmission		Low
Fall	No	Very Low
New or Worsened Pressure Ulcer	No	Medium
New or Remaining Delirium	No	Very Low

Patient Score Card

General:

	Facility	Market	State
LOS	27 days	39 days	33 days
Readmission	24%	32%	29%
Cost	$18K	$21K	$18K

Primary Reason:

	Facility	Market	State
LOS	N/A	40 days	33 days
Readmission	N/A	40%	26%
Cost	N/A	$20K	$16K

PDPM: Non Surgical Orthopedic/Musculoskeletal

	Facility	Market	State
LOS	29 days	42 days	36 days
Readmission	30%	26%	25%
Cost	$11K	$21K	

Drive Increase in Admission Acuity ● Impact Admission Efficiency ● Fuel Accurate Financial Capture ● Promote Safe Transitions ● Reduce RRs

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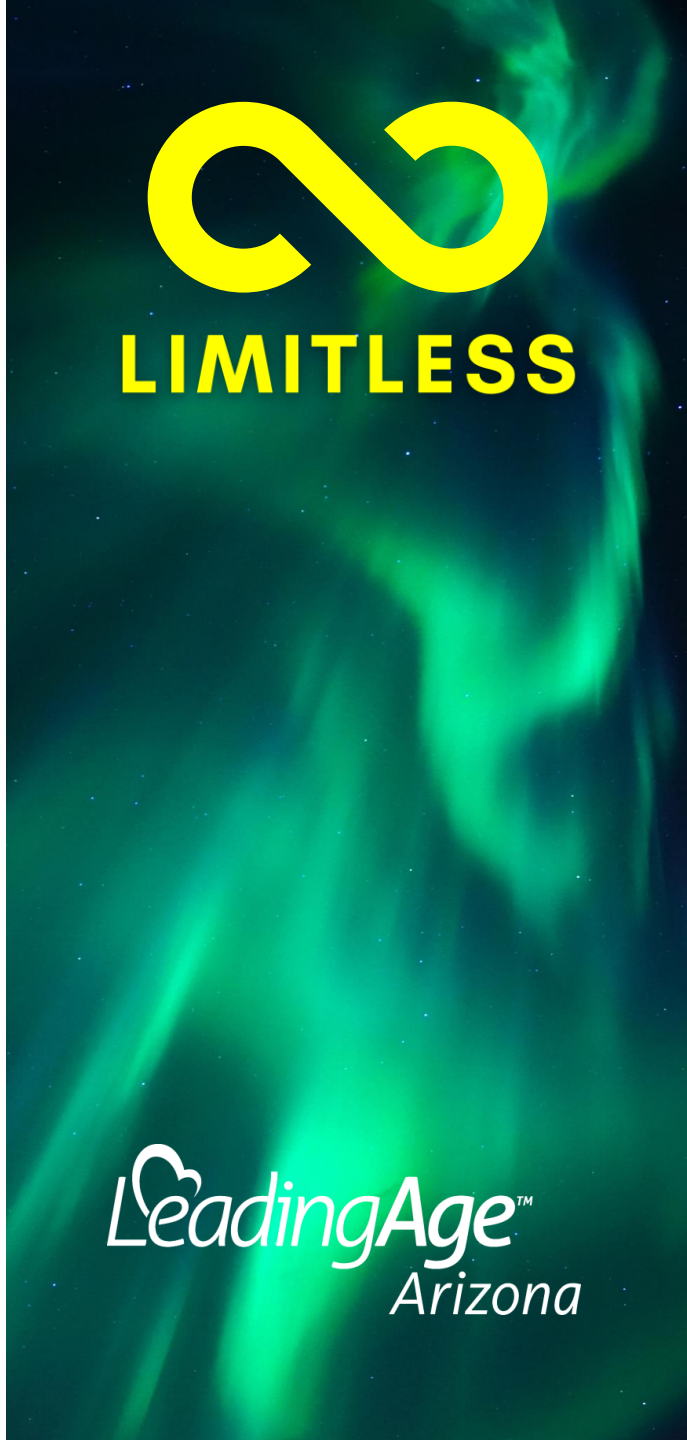
Prepare + Share



Contract Provisions

Even when playing by the rules; they could change

Contract Provisions

Initial Auth letters – maintain each one

Extensions – obtain as early as possible

Appeal process – similar to Medicare appeals.

Chart and explain extenuating circumstances
- Medical interruptions
- Barriers to care: PHE
- Resident resistance

Stick to the Facts

UB-04 to match Dates of Auth

Diagnosis – include all medical barriers from the initial auth; contact MA with added conditions

IPA: confirm the use with the MA. Is interrupted stay consistent with Medicare guidelines?

Physician notes make a difference to get PAID

Resources for the Team

Accuracy + Acuity

HIPPs vs Levels	Contract contents Level qualifiers
Templates Standard + Exceptions	For each level of appeal and extenuating circumstances
Medical Complications + Functional Barriers	Case managers level of expertise Designate + educate
Bill Types	UB contents is critical; dates, dx codes, HIPPs

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Additional Development Requests

Don't miss this first step!

Hierarchy for "Panel Review"

- ✓ Written process

Critical Documentation

- ✓ Make sure all essentials are included

Due Dates make a difference

- ✓ Mark documents with internal + MA

QAPI for process improvement

The Essence of Skilling

Nursing Skilled services are required **daily**

Discuss, Repeat, Mentor, Repeat

Extension of care for a condition for which the individual received inpatient hospital services or if meets waiver criteria

General supervision requires initial direction and periodic inspection of the actual activity

However the supervisor need not always be physically present when services performed

Necessary to improve current condition, to maintain the current condition, or to prevent or slow further deterioration of the condition

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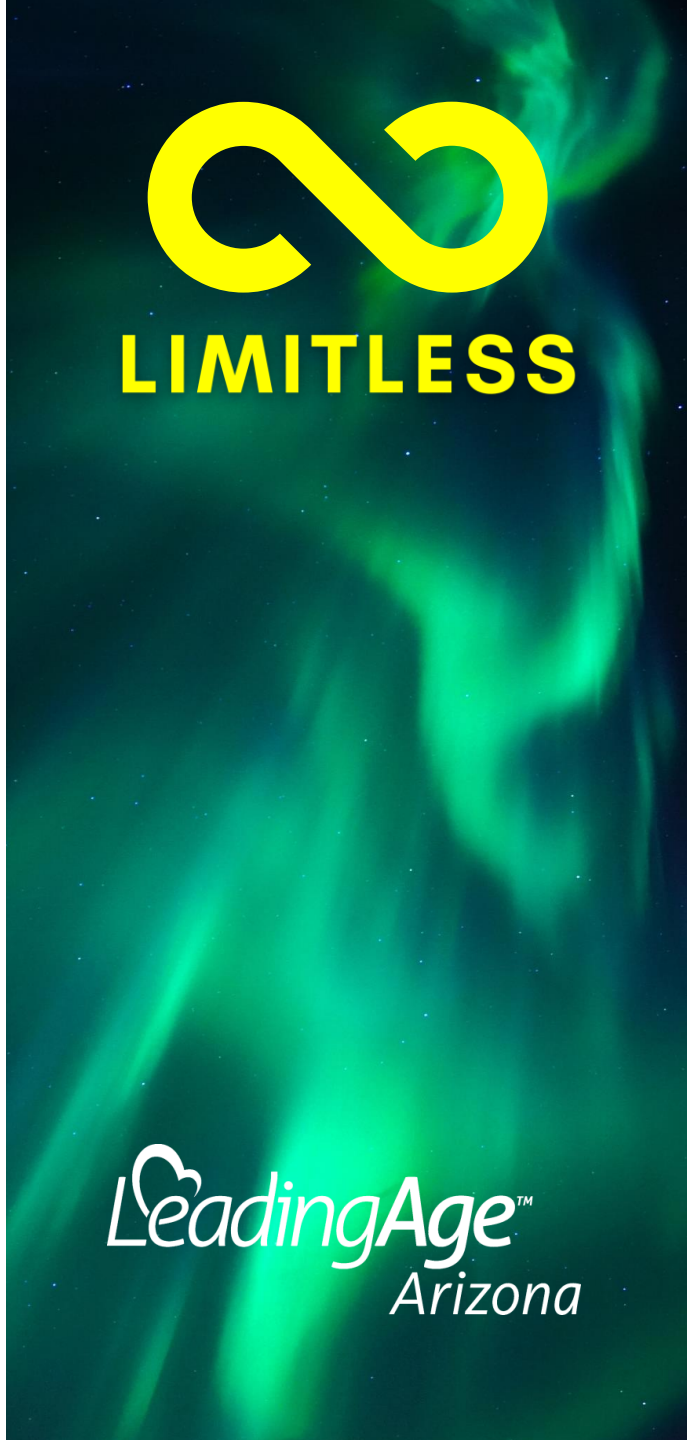
The Essential Ingredients



Medicare Benefit Policy Manual: Chapter 8

Direct Skilled Nursing Services

Management + Evaluation of Care Plan

Observation + Assessment

Teaching + Training

Skilled Rehabilitation

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CLINICAL + TECHNICAL FOCUS

Experienced Reviewer Oversight

- Medical necessity
- Functional deficits
- Standard assessments
- Outcomes

Technical requirements

- Physician Certification
- MDS (5 day + IPA)
- Beneficiary Notices

1135 Waiver

Patients can still get up to 100 days if they are considered skill

Do NOT need 3 day hospital stay, OR 60 day wellness break

Can go to ER, be in observation, hospital 1-2 days, or a LTC resident that you SKILL IN PLACE

Does NOT have to be only COVID-19 symptoms

Additionally:

Pt is in facility that recently exhausted Med A benefit and still requires skilled care:

You do NOT need to wait 60 days, do not need to send to hospital – can convert and cover under Part A

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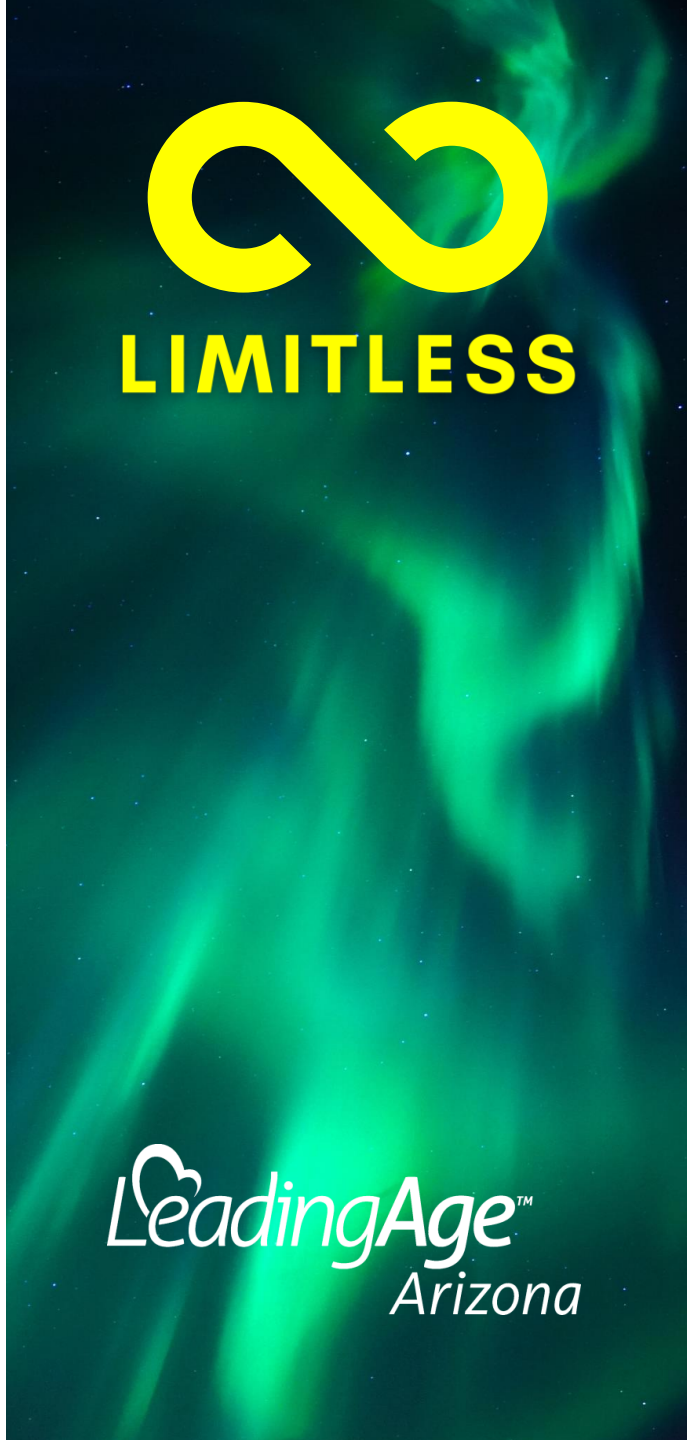
Preparations
Team
Attack



It is a “All Hands on Deck” Approach

Process Owner

Identify who will own + oversee the process

Read Thoroughly

Fully understand what has been requested

Timing

Timeline for response vary between MACs, Managed and other contractors

Packaging

Submit the information as instructed

Labeling

Prompt + accurate processing

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Pivot: Reactive to Proactive Approach

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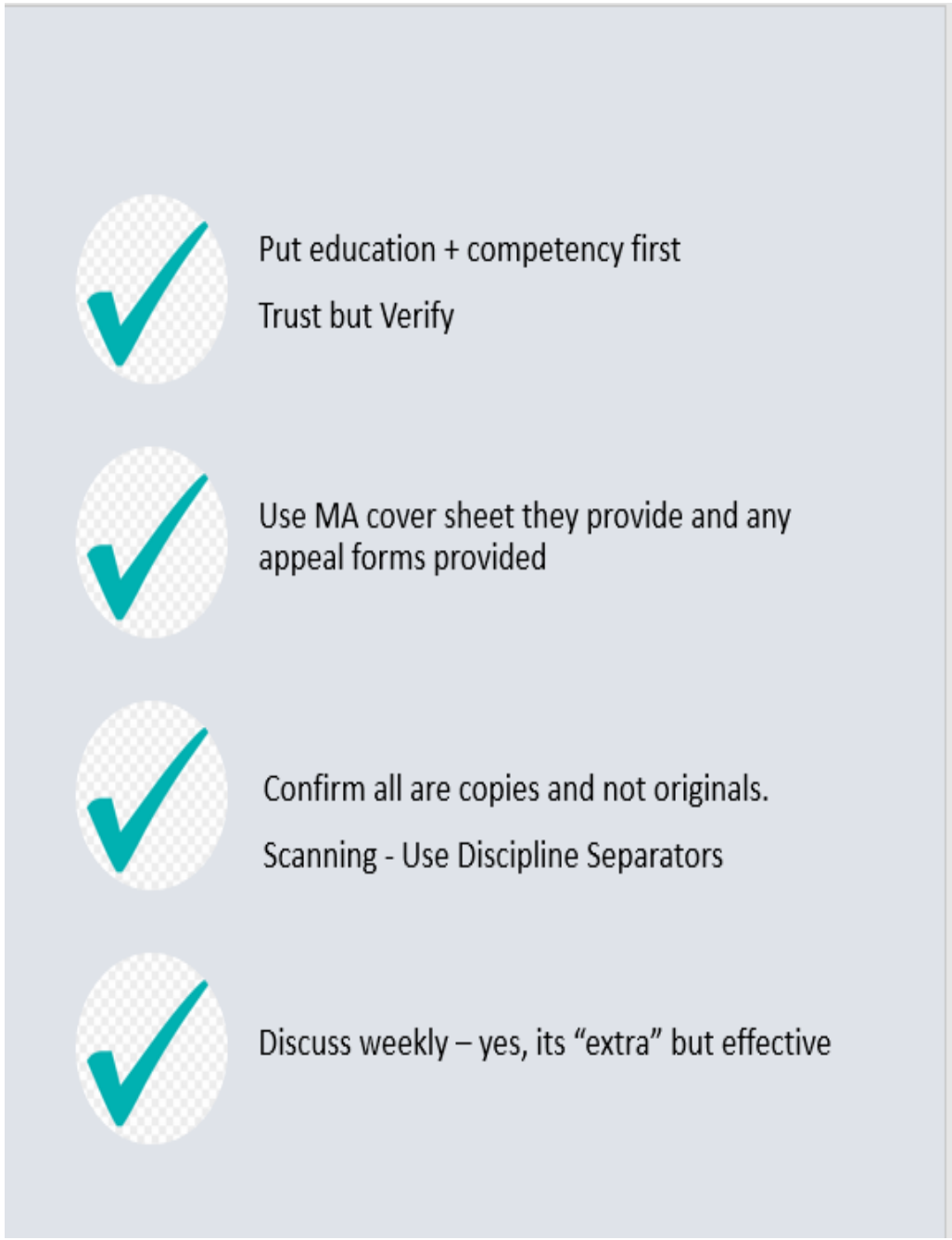
Say Goodbye to being Reactionary



Dispute Request

Humana®

Provider Payment Integrity (PPI)
Medical Record Review Dispute Request Form

What do you want to dispute

Claim #

Patient Account Number

Humana ID

Attached to formal letter of dispute

Original audit findings letter

Ensures routed appropriately

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MA Denial Trends of 2020 - 2022

GG

Isolation

Cognition

Diagnosis support

SLP: Swallow + MAD

ICD-10 Mapping

Does not meet skilled criteria

Not reasonable + necessary

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REBUTTAL STRATEGIES

Denial: GG + Malnutrition

The documentation provided does not appear to support the **Section GG Self-Care Assessment** was completed timely during the first 3 days of the resident's stay.

Also, the documentation provided does not appear to support the diagnosis of **Malnutrition or At Risk of Malnutrition** documented by an MD or other appointed licensed designee

APPEAL LANGUAGE

Enclosed you will find the GG assessment tools completed by XXX, a registered nurse employed by our Center. There is an assessment for each date of xx/xx, xx/xx and xx/xx – the first three days of the resident's stay. There is ample proof that the coding of Section GG was completed in accordance with RAI User's Manual guidelines. There is no evidence in the file that the resident was performing ADL and mobility tasks at an independent level as per the reviewer comments.

Please see enclosed physician documentation from the acute hospital stay noting Protein Malnutrition with ample notions within our medical record in further support of this medical complication + active diagnosis.

Standardized Assessment Tools

Mini Nutritional Assessment

MNA®

Solving the Puzzle

Screening tools

CMS Measures Inventory Tool

Scoring system reveals
- Normal Nutritional status
- At Risk
- Malnourished

Assesses: Food intake, Mobility, Weight loss, Psychological distress

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S-p-e-l-l i-t O-u-t

The decision rational may not be accurate

ADL Self-Performance Rule of 3 Algorithm

START HERE – Review these instructions for Rule of 3 before using the algorithm. **Follow steps in sequence and stop at first level that applies. Start by counting the number of episodes at each ADL Self-Performance Level.**

*** Exceptions to Rule of 3:**

- The Rule of 3 does not apply when coding Independent (0), Total Dependence (4) or Activity Did Not Occur (8), since these levels must be EVERY time the ADL occurred during the look-back period.
- The Rule of 3 does not apply when Activity Occurred Only Once or Twice (7), since the activity did not occur at least 3 times.

Rule of 3:

1. When an activity occurs 3 or more times at any one level, code that level – *note exceptions for Independent (0) and Total Dependence (4).
2. When an activity occurs 3 or more times at multiple levels, code the most dependent level that occurs 3 or more times – *note exceptions for Independent (0) and Total Dependence (4).
3. When an activity occurs 3 or more times and at multiple levels, but NOT 3 times at any one level, apply the following in sequence as listed – stop at the first level that applies: (NOTE: This 3rd rule ***only*** applies if there are **NOT ANY LEVELS that are 3 or more episodes at any one level**. DO NOT proceed to 3a, 3b or 3c unless this criteria is met.)
   a. Convert episodes of Total Dependence (4) to Extensive Assistance (3).
   b. When there is a combination of Total Dependence (4) and Extensive Assist (3) that total 3 or more times – code Extensive Assistance (3).
   c. When there is a combination of Total Dependence (4) and Extensive Assist (3) and/or Limited Assistance (2) that total 3 or more times, code Limited Assistance (2).

   If none of the above are met, code Supervision (1).

Physician Certification was included but not located by reviewers

G or GG daily documentation calculations

IV Fluids administered in the hospital

Evidence of isolation during the lookback

Clarification
SRAIC + RAI Panel

The 5-Day PPS is the first Medicare-required assessment to be completed under a Part A stay, and on this assessment, the functional assessment in Section GG is part of that assessment and must be completed within 3 calendar days of the start of the Part A Stay. For the purposes of the SNF QRP, this is considered the Part A PPS Admission assessment.

When we say that completion of a functional assessment needs to be done within 3 days of the start of the Medicare Part A stay, we mean specifically that. It does not mean that the entire 5-Day PPS must be completed by day 3.

The ARD rules for the 5-Day PPS assessment have not changed, so the 5-Day PPS can have an ARD of day 8, and would still require the appropriate look-back with documentation to support the coding in that section, just as is done for any other section.

This also does not mean that the actual encoding of Section GG must be entered into the computer or on the MDS form within these three days. The encoding rules still apply for PPS assessments, which are that encoding must occur within 7 days after the completion date of the PPS assessment (Z0500B + 7 days).

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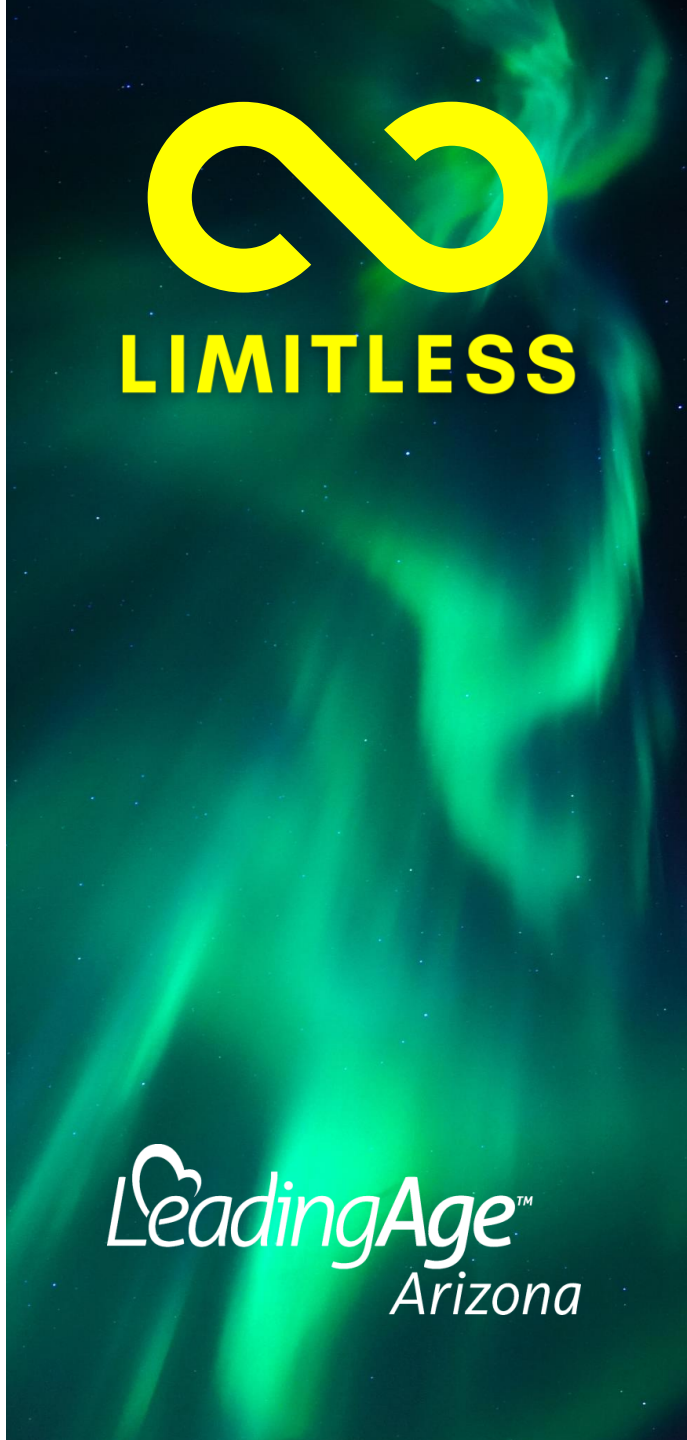
Next Steps + Strategic Discussion



Successful Outcomes

Appeal Progression Maps

Stay connected with MA Appeals Dept

Submit additional evidence

Federal Manuals

SRAIC

Master List; internal + MA connections

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1. The Health Plan
2. Independent Organization
3. Office of Medicare Hearings and Appeals (ALJ)
4. Medicare Appeals Council
5. Federal District Court

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Don’t let this derail your recovery attempts

Assemble the FACTS

Use Appeal Options and Request Extensions

Prevent repeat occurrences

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Appeal Suggestion

Due to extraneous factors including a national health emergency caused by the COVID-19 virus, significantly impacting residents and staff as well as a change in our contract therapy company, the claim appeal was unable to be refiled in a timely manner.

We are requesting an appeal extension at this time and would appreciate a review of the submitted documentation for payment as originally billed. You will see that the medical record contents reveals compliant provision of skilled services and associated billing during the period in question.

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Auth Waivers

For all states, Aetna is temporarily applying the following changes, effective through February 28, 2022:

Skilled Nursing Facility admissions from Acute Hospitals

- Initial Precertification/Prior Authorization for admission from acute care hospitals to Skilled Nursing Facilities (SNF) are **waived** for all Commercial and Medicare Advantage (MA) Part C plans.

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ESCALATE CONCERNS

The Appeal Process may not be enough

Resolution Committee

Connect with the MA Communications Center

Call Schedule

Weekly
Biweekly
Monthly

Assemble Evidence

Claims examples
Regulatory Guidance
Follow up communications

Stay the Course

MA managers may use slight of hand

"That is handled by a different department"

How to Ease Tracking Access

Create an online database

- ✓Provide team access
- ✓Complete during Clinical Forums
- ✓Color code to guide discussions
- ✓Upload documents
- ✓Comment exchange
- ✓Link to Box files

smartsheet

Denials

Grid View | Unnamed Filter | Arial | 10

	Date Added	Facility / Agency Name	Patient Last Name	Patient First Name	From Date	Thru Date	Appeal Level

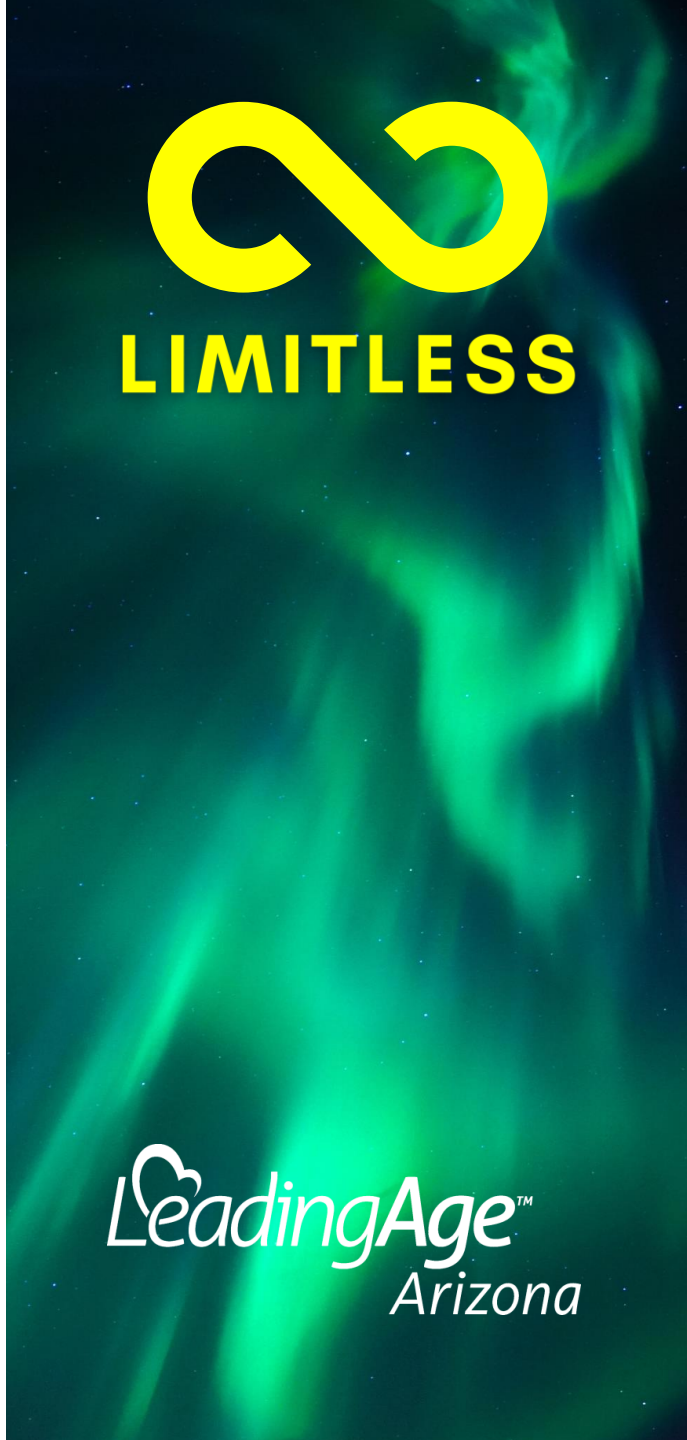
envision everything
with HealthPRO Heritage

APPLY CONTINUOUS PRESSURE

- *"....there was no evidence that the neuromuscular re-education was for an impairment which affected the body's neuromuscular system. Neuromuscular re-education (97112) is provided to improve balance, coordination, kinesthetic sense, posture, and proprioception to a person who had an impairment which affected the body's neuromuscular system such as severe trauma to the nervous system, cerebrovascular accident (CVA) and systemic neurological disease.* ***The documentation did not support the coding 97112.***
  REFERENCES As per the Medicare Benefit Policy Manual, Chapter 8:30..4.1.1, the services must be considered under accepted standards of medical practice to be specific and effective treatment for the patient's condition."

Denial Reason following Complex Medical Review:

- 97112 – Neuromuscular Re-education
- Payor was seeking neurological diagnosis



The Global Approach

What we did

- Researched extensively

Compiled a detailed white paper

Reached out to AOTA and APTA

Submitted a statement to:

- CMS
- Cotiviti
- Aetna
- United Healthcare

Outcome

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CMS

- Agreed with our assessment
- Directed Cotiviti to no longer use this denial reason
- Over-turned all denials for this reason

United HealthCare

- Agreed with our assessment
- Evaluating next steps

Aetna

- Commented "Still reviewing the complaint"

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The Global Approach had a bigger impact

Proactive QAPI Approach

Proactively Reduce Requests

- Documentation education scheduled regularly with competencies
- Confirm level of care for billing accuracy
- Clinical meeting discussions including outstanding claims

Efficiently Respond

- Timely notice to all team members
- Checklists for all documentation necessary
- Verify HIPPs or Levels

Winning!

- Keep templates in a shared drive and notify team members
- Save drafts from Paid Claims
- Share findings in clinical forums

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TAKEAWAYS

Refresh Workflows + Process Inefficiencies

PDPM Tools – Keep them handy!

Resume Face to Face IDT Clinical Exchanges

Identify a consistent clinical forum +
add to agenda

Bring every claim under review to clinical

ALL Members of the Team are essential

Organize your submissions;
Set a process for verification

iQIES Launch

CMS announced iQIES
Internet Quality Improvement Evaluation System

MDS submission 2023

Providers to assign PSO;
Provider Security Officials

PSO grants User Roles;
Required to upload assessments or generate and view reports for their facility

Recommend at least 2 POS are designated; the 1st PSO must be approved by CMS

Manuals/Guides

Job Aide for PSO describes the responsibilities and steps for onboarding

Establish a HARP account

Contact Help Desk with any complications
iQIES@cms.hhs.gov

Link to Reference + Manuals

THANK YOU

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