



Be Prepared for Medicare/Medicaid Medical Audit and Review

Currently, skilled nursing facilities are experiencing a significant number of special audits conducted by the Medicare program and some state Medicaid programs. The focus of these audits is to determine: (1) the accuracy of the MDS and the related assessment and case-mix determination, (2) the completeness of clinical documentation, and (3) whether services provided are medically reasonable and necessary.

Most of these special audits are being conducted on a post-payment basis on claims that have been processed previously without medical review. Many are focusing on Medicare Part A claims paid under the RUGs payment system. In the past, Part A claims have had minimal review, therefore, providers are inexperienced with the process. When these post-payment audits expose problems or errors, expanded audits are being conducted on a pre-payment basis.

The following is a list of some of the special audits conducted:

Probe Audits - Statistical sampling reviews of selected types of claims by the Medicare Fiscal Intermediary (FI) or Medicare's Program Safeguard Contractors (PSC)

DAVE Audits - CMS Data Assessment and Verification Project audit of the MDS by Computer Sciences Corporation

CERT Reviews - Comprehensive Error Rate Testing of the Medicare billing by the FI

OIG Audits - Audits by the Office of the Inspector General of selected providers based upon identified billing problems, unusual billing patterns or practices, or specific complaints made by third parties



State Medicaid CMI Audits - Audits by state Medicaid programs to determine the accuracy of a provider's case-mix payment.

Before You Are Audited

All facilities will be audited at some point, so it is best to be prepared now. Nursing and rehab should establish an internal audit group to review medical records for accuracy and completeness. Also important are the correctness of the MDS, proper use of the MDS "look back" periods, correct calculation of rehab minutes, and complete nursing and rehab notes. Physician's orders and certs/recerts should be properly signed and dated. These reviews should include a determination of whether or not the nursing and rehab notes are descriptive of the patient and not in conflict with regard to the patient's condition.

Responding To An Audit

Since these audits are performed post-payment, providers usually do not feel the sense of urgency associated with a pre-payment audit. However, these audits can have a dramatic long-term negative effect on cash flow, and should be responded to with some level of priority. It is important that everyone involved in billing, documentation and clinical services be aware when a special audit is being conducted, and that there is a collective effort in the response.

Prior to sending in a response, review documentation thoroughly for completeness and accuracy. Copied documentation should be legible, with properly ordered and numbered pages, and include a cover letter explicitly stating what is being sent in response to the audit. This review should also ensure that all requested documentation is being provided, and that documentation relative to both the payment period and the RUG's "look back" period is provided.

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All documentation should be sent with a cover letter on facility letterhead, dated, with the name and phone number of a contact person at the facility, and a list of all documentation being sent.

Maintaining Audit Files

As part of the audit response, the facility should establish an audit file. This file should include the request letter and a copy of everything sent in response to that request. Even though patient documentation sent in response to an audit will also be in medical records, a copy of everything sent should be maintained in the audit file. This will ensure that if there is a question about what was submitted, that question can be answered. The file should also note the date documentation was sent, to whom and to where it was sent, a copy of the cover letter, and all follow-up correspondence pertaining to the audit. Should there be any telephonic or in-person conversations with the auditors, this information should be recorded and included in the audit file. Following many Probe audits, the FI will conduct a telephonic training session. This information also should be recorded, indicating who was on the call and what was discussed.

Many DAVE audits are now being conducted on-site. Again, extra copies of any documentation given to the auditors should be maintained in an audit file. All information from conversations, including what patient documentation was reviewed, should also be noted in the file. A record should be kept of what patient documentation was reviewed. Auditors should be properly identified, and names, titles, addresses and phone numbers of the auditors should be included in the audit file.

If there is a denial, the audit file will assist during the appeal process in determining what documentation was reviewed in making that decision.

Appealing Audit Denials

Post-payment denials can be appealed in accordance with the normal appeals procedures. Appeals should be prepared as quickly as possible to insure prompt attention

by Medicare. Medicaid case mix denials should be appealed based upon the state regulations and instructions relating to the audit.

Effect Of Audit

Quick and accurate response to these audits will not only reduce the number of claims being denied, but will reduce the paperwork required to appeal denials and the potential for increased audit work as a result of expanded audits. Since most of these audits relate to Medicare Part A services, the denial amounts are often quite large. Quick and accurate response will also reduce the amount of a provider's cash being tied up by denials.

Appropriate denial response will also reduce the amount of scrutiny of claims by the FIs and the number of requests for documentation in the future.

Peoplefirst and Special Audits

The Peoplefirst Client and Clinical Services staff has a significant amount of experience handling these special audits and assisting our clients in responding to them.

If you need assistance, please contact our National Director of Client Services, John Eanes, at 678-393-3916 or via email at john.eanes@kindredhealthcare.com.

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