Module 16: How to Read A Medical File

Objectives

At the completion of this lesson, you will be able to:

- Understand the general principles of medical record documentation and organization;
- Identify sections of the medical record file; and
- Describe the "how to" steps to find OMHA relevant information in a medical file.

Objective 1:

Understand the general principles of medical record documentation and organization

What is a Medical Record?

- Documents the individual's health history, status, and prognosis
- Provides evidence that items/services were rendered as billed

Documentation Standards (1-4)

42 C.F.R. § 482.24(c)

Provides that as a condition of participation in Medicare, participating hospitals must maintain a medical record of every individual evaluated or treated in the hospital.

Documentation Standards (2-4)

42 C.F.R. § 482.24(c)- The medical record must contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response.

Documentation Standards (3-4)

Documentation for each encounter should include:

- Reason for the encounter and relevant history, physician examination findings, prior test results;
- Assessment or clinical impression of patient's presenting healthcare issue (e.g., current medications);

Documentation Standards (4-4)

Documentation for each encounter should include:

- Proposed diagnosis;
- Plan of care; and
- Date and legible identity of the caregiver

Objective 2:

Identify sections of the medical record file

Components of A Record (1-4)

- Admission Note or Face Sheet
- ER Records
- History and Physical

Components of A Record (2-4)

- Physician Progress Notes
- Consultation Reports
- Medication Record

Components of A Record (3-4)

- Nursing Admission and Notes
- Care Plan
- Diagnostic Test Results

Components of A Record (4-4)

- Physician Orders
- Operative Report
- Therapy Notes
- Discharge Summary

Admission Nursing Record - Example

ADMISSION NURSING FLOW SHEET

Resident Name: (b)(6) Admission Date: 11/10/10 TIME: 2300

Arrived via: ☐ Ambulatory ☒ Stretcher ☐ Wheel Chair

Admitted from: ☒ Hospital ☐ Home ☐ Nursing Home ☐ Emergency Room ☐ Other _____

VITAL SIGNS: T 98 P 88 IR R 20 BP (R) _____ (L) 132/72 Height _____ Weight _____

ADMITTING DX _____

Patient/resident stated reason for admission: _____

ALLERGIES: (include food, drugs, tape, soap, etc.,) _____

COMMUNICATION: Language: ☒ English ☐ Other: _____

PROSTHESIS: ☒ Dentures ☐ Contact lenses ☐ Eye ☐ Walker ☐ Glasses ☐ Hearing Aid
☐ Limb ☐ Cane ☐ Crutches ☐ Other _____

PATIENT HAS VALUABLES/PROPERTY: ☐ Yes ☒ No Disposition: ☐ Home with family ☐ At bedside (see belongings list)

IDENTIFICATION BAND: ☒ Yes ☐ No

ORIENTATION TO FACILITY ENVIRONMENT:

Verbalizes/Demonstrates use of: ☒ Nursing call bell ☐ Bed controls ☐ Side rails ☒ TV ☐ Telephone ☐ Unable

Comments: _____

LIFESTYLE: ☐ Current smoker ☐ Non smoker ☐ Alcohol/Drug use (daily amount) _____

History and Physical - Example

ADMISSION HISTORY AND PHYSICAL

Patient's Name:
Date of Birth: (b)(6)
Medical Record #:
Date of Admission:
Date of Examination: 6/6/08
Attending Physician:
Referring Physician:

HISTORY OF PRESENT ILLNESS: This is a pleasant 83-year-old who had bilateral total knee replacements by on 06/03/08 at
She actually had had an increasing problem with pain over the last few months, more numbness in her feet. She had had a workup with an MRI that showed bilateral degenerative joint disease and she was not doing well. She lives in unable to get around as well, could not walk much and so she was admitted for surgery and has been slow to recovery, particularly with bilateral knees. There are no other specific medical problems.

PAST MEDICAL HISTORY: Significant for osteoarthritis.

History and Physical – Example (Con't)

ALLERGIES: None.

CURRENT MEDICATIONS:

1. Iron 325 mg twice a day.
2. Pepcid 40 mg a day.
3. Colace 100 mg b.i.d.
4. Risedronate 35 mg q. week.
5. Vitamin C 500 mg a day.
6. Multivitamins.
7. Calcium 500 mg daily.
8. Senna.
9. Ambien 5 mg daily.
10. Zofran.
11. Vicodin for pain.

SOCIAL HISTORY: Retired bank teller who lives alone. Nonsmoker, nondrinker. Is going to be in the home will take care of her when she goes home.

FAMILY HISTORY: Unremarkable.

History and Physical – Example (Con't)

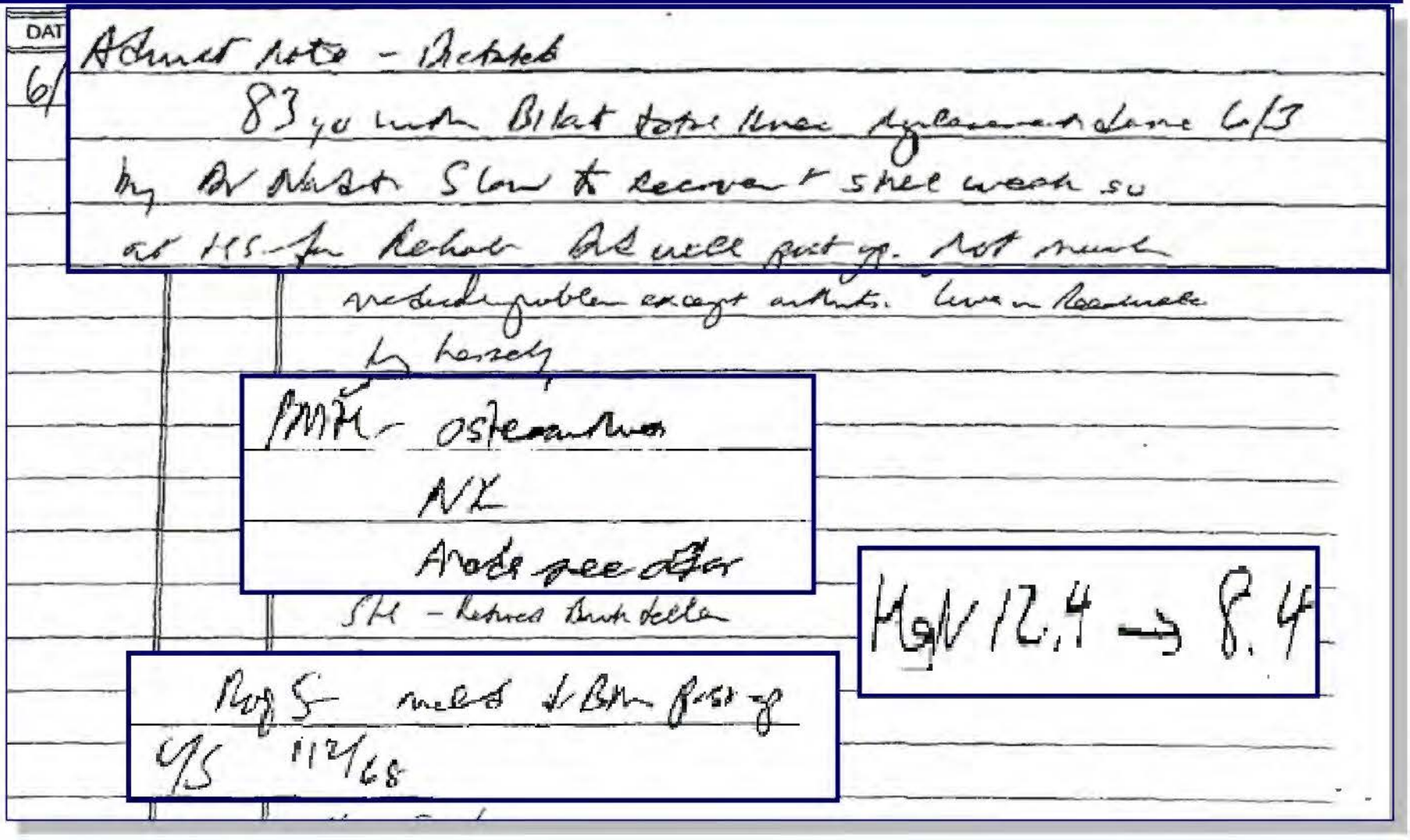
REVIEW OF SYSTEMS: Denies any headaches or vision troubles. She does have some increased pain when she walks, but otherwise joints are not too bad. No chest pain, shortness of breath, nausea, vomiting. Does have some constipation since surgery on 06/03/08. No urine troubles. No burning. Slow to move around, but is able to walk with a walker. No allergy troubles, psychiatric troubles, endocrine abnormality, hematologic difficulties.

PHYSICAL EXAMINATION:
VITAL SIGNS: Blood pressure is 112/68.
HEENT: Extraocular movements intact. Pupils equal and reactive to light. Mouth is normal.
NECK: Supple. No carotid bruits. No enlarged thyroid.
CHEST: Clear.
HEART: Regular rate and rhythm without murmur or gallop.
ABDOMEN: Soft, nontender with no enlarged liver, spleen or kidneys.
EXTREMITIES: Does have bilateral knee incisions that are healing, and 1+ edema. Pulses are present, 2+.

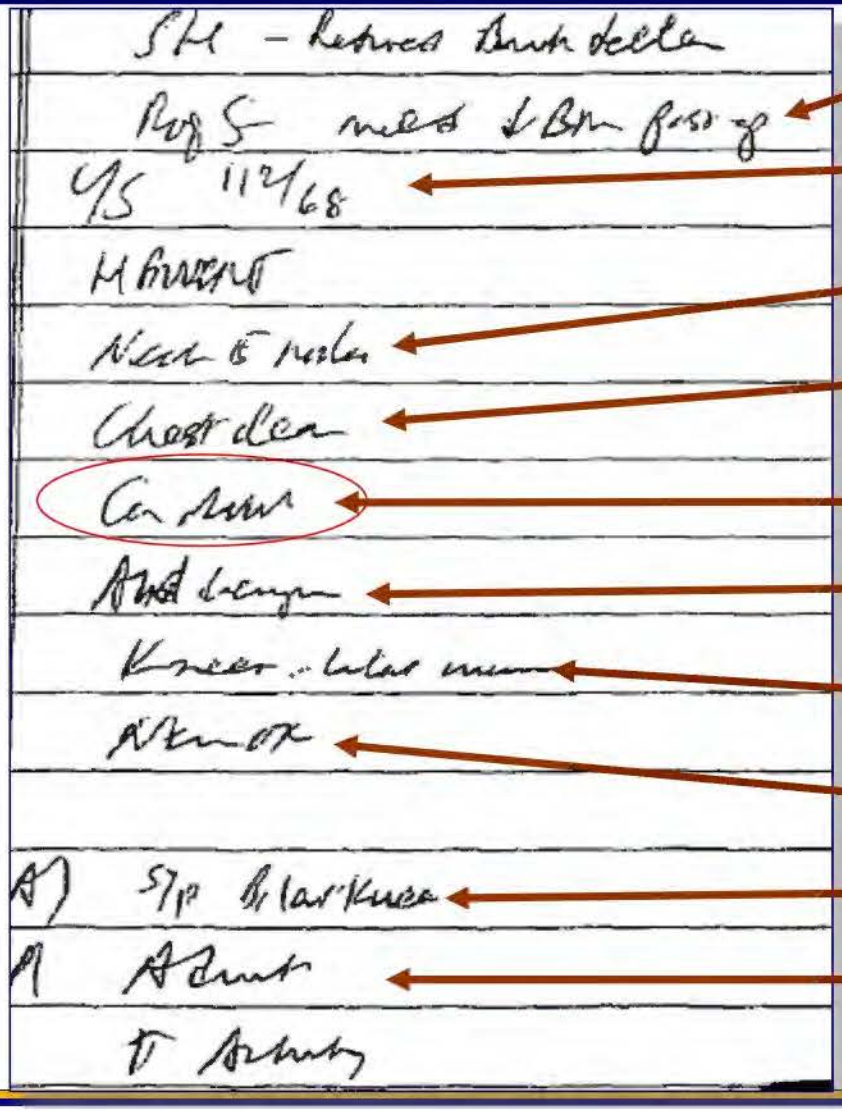
LABORATORY DATA: She went from a hemoglobin of 12.4 down to 8.4 postoperative.

ASSESSMENT:
Bilateral knee surgery. Will closely monitor for followup with anemia. She is going to have her Coumadin adjusted accordingly. She will increase activity, begin OT/PT consult, and have for rehabilitation evaluation.

Physician Progress Notes - Example



Physician Progress Notes (Con't)



R of S – Review of Systems

VS – Vital Signs 112/68

Neck without nodes

Chest Clear

????

Abd (Abdomen) benign

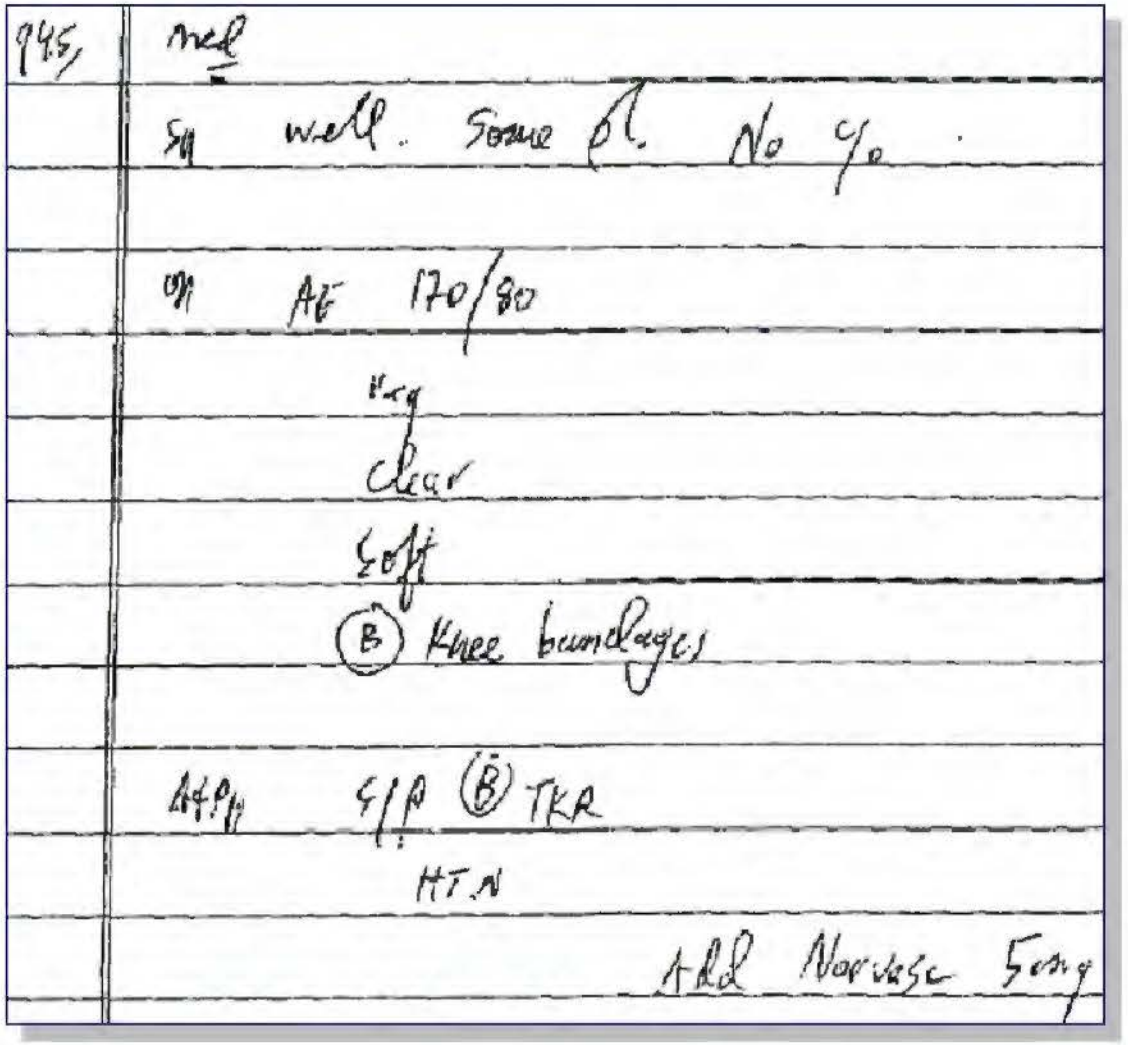
Knees – bilateral (2) incisions

Neuro OK

S/P – Status Post Bilat knee

Admit

Physician Progress Notes (Con't)



S = Well – Some ??? - No C/O (complaints)

O = 170/80, Reg, clear, soft, (B) Knee bandages

A&P = S/P B TKR HTN

Add Norvasc 5 mg

Progress Notes - Example

DAILY ROUNDS

6/9/08

S: I see . in followup. She is doing reasonably well. Knee incisions are clean. Pain control appears to be slightly improved. GI upset is better. She is having bowel movements. Blood pressure control has improved.

O: COR: Regular rate and rhythm. LUNGS: There are coarse breath sounds. ABDOMEN: Active bowel sounds. Nontender. EXTREMITIES: Negative clubbing, cyanosis or Homans'. Neurologically intact. There is no regional lymphadenopathy. Skin integrity is intact.

A/P: Making slow progress.

Progress Notes – Example (Con't)

DAILY ROUNDS

6/10/08

S: I see [redacted] in followup. Blood press[redacted] Dyspepsia is improved.
Obstipation has resolved. She is complaining of knee pain. Was unable to take [redacted] more frequently due to the Tylenol component and I will change her to Oxy IR.

O: COR: Regular rate and rhythm. LUNGS: There are coarse breath sounds. ABDOMEN: Active bowel sounds, nontender. EXTREMITIES: Negative clubbing, cyanosis or Homans'.

A/P: As above. Blood pressure is improved. Repeat BMP pending. Making good improvement. Still very limited ambulation but range of motion is markedly better.

Progress Notes – Example (Con't)

DAILY ROUNDS

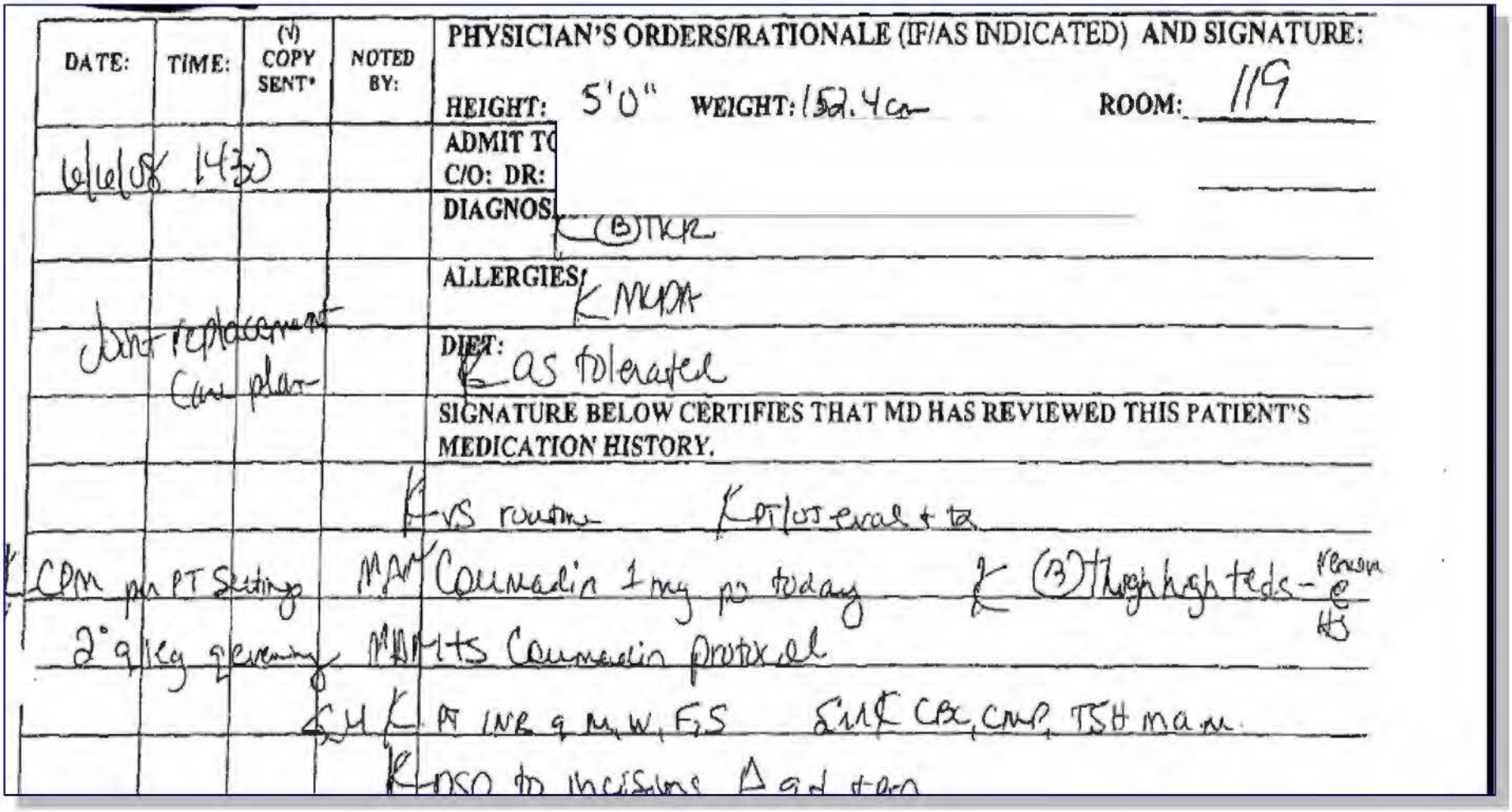
6/11/08

S: I see [redacted] followup. Knee range of motion is improving. Pain control appears to be adequate. Edema is reasonably controlled. Hemoglobin and hematocrit are stable. She is yet to trial any elevations. I have explained to her that this is obviously a critical issue with discharge to the community as she has 10 stairs to access even the home she is choosing to go to which is more accessible. Blood pressure is adequately controlled. Obstipation has resolved.

O: COR: Regular rate and rhythm. LUNGS: Clear. ABDOMEN: Active bowel sounds, nontender.

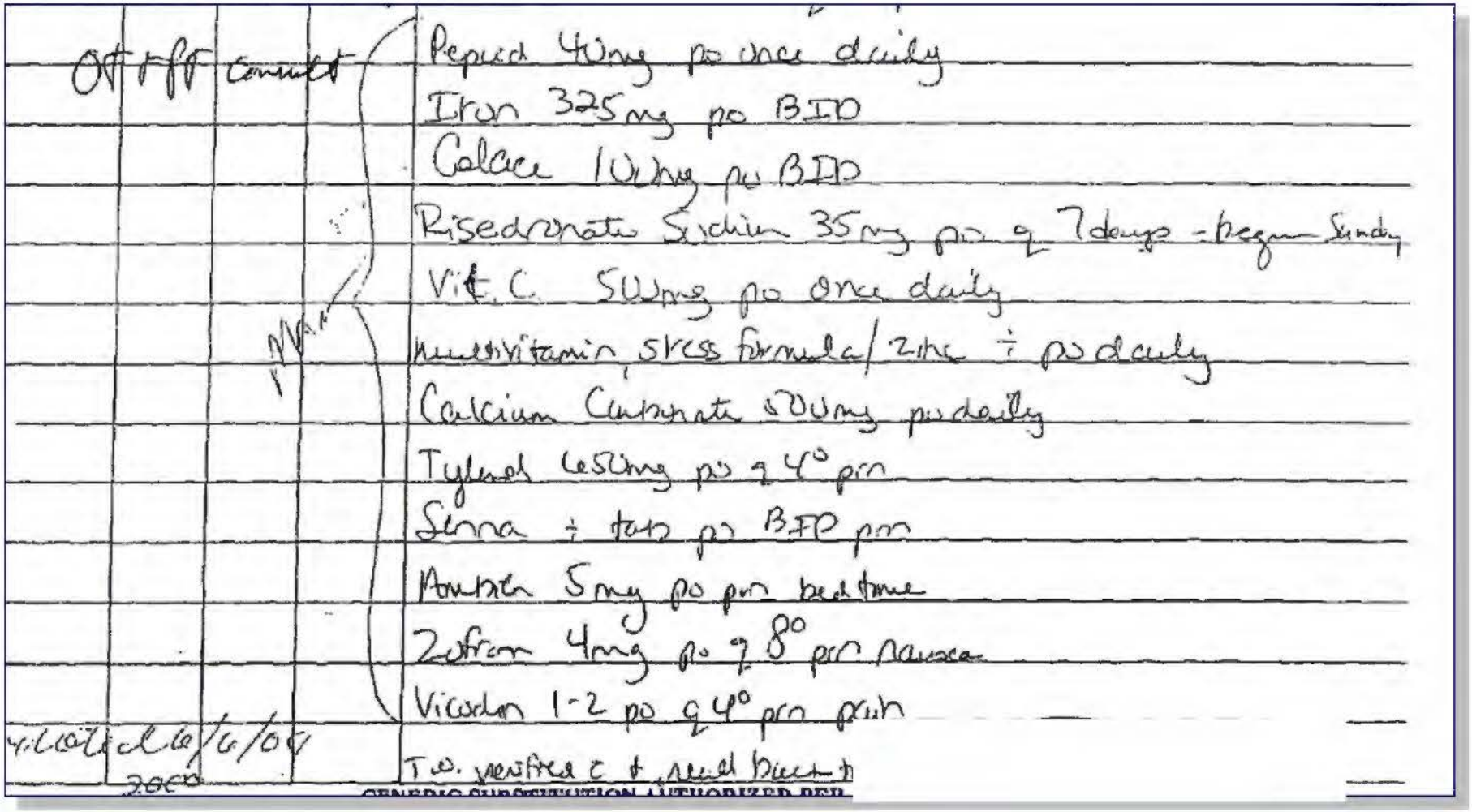
A/P: None given.

Physician's Orders - Example



DATE:	TIME:	(√) COPY SENT*	NOTED BY:	PHYSICIAN'S ORDERS/RATIONALE (IF/AS INDICATED) AND SIGNATURE:
				HEIGHT: 5'0" WEIGHT: 152.4 lbs ROOM: 119
6/6/08	1430			ADMIT TO:
				C/O: DR:
				DIAGNOS: (B) TKR
				ALLERGIES: K NKDA
				Joint replacement Care plan
				DIET: K as tolerated
				SIGNATURE BELOW CERTIFIES THAT MD HAS REVIEWED THIS PATIENT'S MEDICATION HISTORY.
			K	K VS routine K OT/OT eval + tx
K CPM per PT Setting			MAR	Coumadin 1 mg po today K (3) Thigh high teds - reason e HS
2° q leg elevation			MAR	Pts Coumadin protocol
			SH K	PT INR q M, W, F, S SH K CBC, CMP, TSH mam.
			K	NSO to incisions Δ and then

Physician's Orders (Con't)



Discharge Summary (1-4)

- One of the most important documents in the medical record
- Should provide an overview of the hospitalization (e.g., Inpatient, SNF, IRF)

Discharge Summary (2-4)

- Attending physician must complete the discharge summary within 30 days of discharge

Discharge Summary (3-4)

- Includes:
  - A description of patient's course in the hospital or facility
  - Any procedures and treatments
  - Medications

Discharge Summary (4-4)

- Includes:
  - Complications and comorbidity
  - Discharge plan
  - Patient status at the time of discharge

Discharge Summary - Example

Report Date & Time: 10Nov10 9:23am
Report Name : Discharge Summary

########## PRELIMINARY REPORT ##########

DISCHARGE DIAGNOSIS:

Acute Shortness of Breath
Congestive Heart Failure/ Mitral Valve Replacement/ Non Ischemic Cardiomyopathy with Ejection fraction of 15%. Chronic Atrial Fibrillation and Status Post ASAD Placement.
Non Insulin Dependent Diabetes Mellitus
Status Post CVA and <_____>
Peripheral Vascular Disease, Status Post Left Below Knee Amputation
Chronic Obstructive Pulmonary Disease
GERD
Depression
DISCHARGE SUMMARY:
HISTORY OF PRESENT ILLNESS:

Mr. is a 59 year old black male who has been living in a long term care facility and was brought in because of shortness of breath. He was doing fairly well until the day of admission when it was realized that he has been having diarrhea about 5 to 6 times a day for about 10 days or so and the thought was he was dehydrated and the blood pressure was low at the time and so he was sent to the Emergency Department. When he was seen he had a blood pressure of 90/60. Heart rate was 120. Pulse ox was 98% on two liters of oxygen. He did not look well at the time and tongue was dry and he did complain of diarrhea at the time. Heart - S1, S2 heard. No murmurs. Abdomen was soft, non tender. Extremities - no clubbing, cyanosis. There was a left below knee amputation. He was oriented and <_____>. He did have dysarthria making it difficult to understand him fairly well.

Discharge Summary (Con't)

LABORATORY DATA: Showed a white cell count of 5.9. Hemoglobin of 11.3. hematocrit of 34.3. Platelets 80. BUN was 20 and creatinine was 1.2. Glucose was 125. Potassium was 5.8. Sodium was 144. INR was 1.4. BNP at this time was 652. LFT's were within normal limits.

Chest x-ray showed cardiomegaly and status post open heart surgery. Mitral valve replacement, moderate CHF. EKG showed <_____> 100 beats per minute. No acute changes was seen. It was thought at the time that he was debydrated secondary to diarrhea and so he was started on some normal saline at a very gentle rate of about 60 ml per hour and his labs were done the next day again and he was continued on his Januvia but we did withhold all his cardiac medications for the time being, <_____> Warfarin. He was admitted because he was so precarious with severe coronary artery disease, CHF. He was admitted to the 2nd floor, 2-2 which is a congestive heart failure

Discharge Summary (Con't)

Dr. C saw him the next day and Dr. thought Mr. was again in failure and so he was started again on IV Lasix 40 mg twice a day and his was maintained and it was made sure that he also improved. His cardiac medications were again restarted and because <_____> he was put on Heparin for the time being.

Under this treatment Mr. ; started perking up and his shortness of breath has gotten better. He feels much better now and during his stay he has been quite asymptomatic otherwise. Yesterday we were going to discharge him when he had a bout of V tach on the monitor and this showed a bout of about 13 beats of Vtach and so he was kept for one more day and today Dr. questioned <_____> of his ASCD and lower the threshold for his ASCD. This continues much better, he is being discharged back to the Community. His last labs show a INR of 2.5. BUN was about 25 and creatinine was 1.3. INR is 5. Hemoglobin 10.9, hematocrit 34.1 and platelets are 84. He is being sent back to a nursing home with a request for a BMP and INR on next Monday. To see Dr. in about two weeks time and of course it is important to maintain his INR at least about 2 , between 2 and 3. He has been put back on his medications as the threshold of the AICD has been reduced at this time, we would like to keep the Coreg to be a little higher. Coreg has been increased to 25 mg twice a day, hopefully Mr. Thomas will tolerate that. Lisinopril is being withheld for the time being and also the Losartan has been reduced to 40 mg q day. His diabetes has been under control.

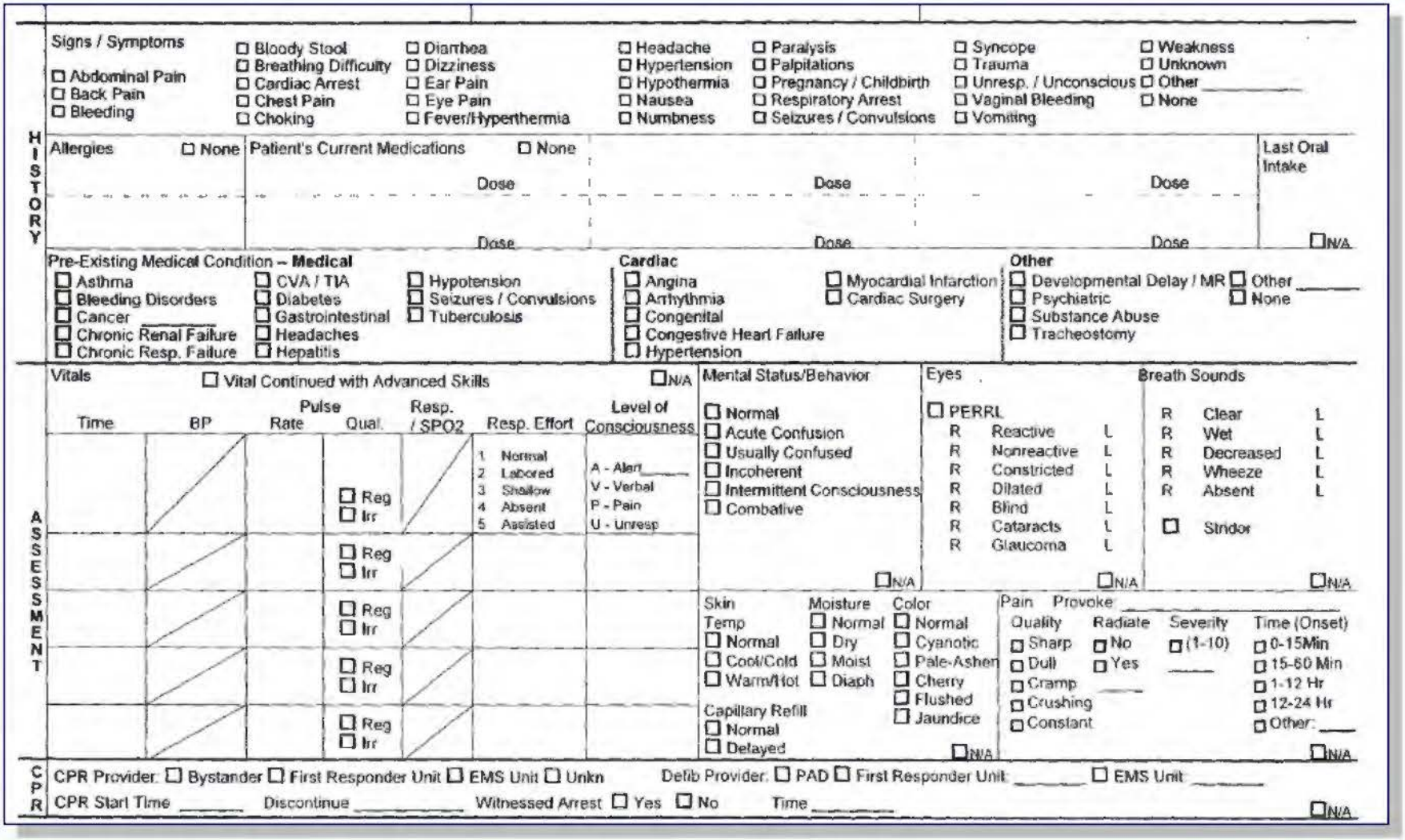
Discharge Summary (Con't)

The medications he is going to be discharged on :

Coreg 20 mg one tablet twice a day
Valsartan 40 mg one tablet p.o. q a m <_____? Losartan just above?_____>
Lasix 40 mg one tablet p.o. twice a day
Warfarin 2.7 mg one table p.o. q d
Omeprazole 20 mg one tablet p.o. q d
Potassium chloride
K Dur 20 mg p.o. twice a day after food.
Zoloft 100 mg one tablet p.o. q a m
Januvia 40 mg one tablet p.o. q a m
Digoxin .125 mg p.o. q d
Aspirin 81 mg p.o. q d

; mentioned before his INR and basic metabolic panel to be done on Monday and will follow up.

Ambulance Run Report - Example



HISTORY

Signs / Symptoms

☐ Abdominal Pain ☐ Back Pain ☐ Bleeding ☐ Bloody Stool ☐ Breathing Difficulty ☐ Cardiac Arrest ☐ Chest Pain ☐ Choking ☐ Diarrhea ☐ Dizziness ☐ Ear Pain ☐ Eye Pain ☐ Fever/Hyperthermia ☐ Headache ☐ Hypertension ☐ Hypothermia ☐ Nausea ☐ Numbness ☐ Paralysis ☐ Palpitations ☐ Pregnancy / Childbirth ☐ Respiratory Arrest ☐ Seizures / Convulsions ☐ Syncope ☐ Trauma ☐ Unresp. / Unconscious ☐ Vaginal Bleeding ☐ Vomiting ☐ Weakness ☐ Unknown ☐ Other _____ ☐ None

Allergies ☐ None

Patient's Current Medications ☐ None — Dose — Dose — Dose — Dose — Dose — Dose

Last Oral Intake ☐ N/A

Pre-Existing Medical Condition – **Medical**

☐ Asthma ☐ Bleeding Disorders ☐ Cancer _____ ☐ Chronic Renal Failure ☐ Chronic Resp. Failure ☐ CVA / TIA ☐ Diabetes ☐ Gastrointestinal ☐ Headaches ☐ Hepatitis ☐ Hypotension ☐ Seizures / Convulsions ☐ Tuberculosis

Cardiac

☐ Angina ☐ Arrhythmia ☐ Congenital ☐ Congestive Heart Failure ☐ Hypertension ☐ Myocardial Infarction ☐ Cardiac Surgery

Other

☐ Developmental Delay / MR ☐ Psychiatric ☐ Substance Abuse ☐ Tracheostomy ☐ Other _____ ☐ None

ASSESSMENT

Vitals ☐ Vital Continued with Advanced Skills ☐ N/A

Time	BP	Pulse Rate	Pulse Qual.	Resp. / SPO2	Resp. Effort	Level of Consciousness
			☐ Reg ☐ Irr		1 Normal 2 Labored 3 Shallow 4 Absent 5 Assisted	A - Alert V - Verbal P - Pain U - Unresp
			☐ Reg ☐ Irr			
			☐ Reg ☐ Irr			
			☐ Reg ☐ Irr			
			☐ Reg ☐ Irr			

Mental Status/Behavior

☐ Normal ☐ Acute Confusion ☐ Usually Confused ☐ Incoherent ☐ Intermittent Consciousness ☐ Combative ☐ N/A

Eyes

☐ PERRL

R	Reactive	L
R	Nonreactive	L
R	Constricted	L
R	Dilated	L
R	Blind	L
R	Cataracts	L
R	Glaucoma	L

☐ N/A

Breath Sounds

R	Clear	L
R	Wet	L
R	Decreased	L
R	Wheeze	L
R	Absent	L

☐ Stridor ☐ N/A

Skin Temp ☐ Normal ☐ Cool/Cold ☐ Warm/Hot

Moisture ☐ Normal ☐ Dry ☐ Moist ☐ Diaph

Color ☐ Normal ☐ Cyanotic ☐ Pale-Ashen ☐ Cherry ☐ Flushed ☐ Jaundice

Capillary Refill ☐ Normal ☐ Delayed ☐ N/A

Pain Provoke _____

Quality	Radiate	Severity	Time (Onset)
☐ Sharp	☐ No	☐ (1-10)	☐ 0-15Min
☐ Dull	☐ Yes	_____	☐ 15-60 Min
☐ Cramp	_____		☐ 1-12 Hr
☐ Crushing			☐ 12-24 Hr
☐ Constant			☐ Other: _____

☐ N/A

CPR

CPR Provider: ☐ Bystander ☐ First Responder Unit ☐ EMS Unit ☐ Unkn

Defib Provider: ☐ PAD ☐ First Responder Unit _____ ☐ EMS Unit _____

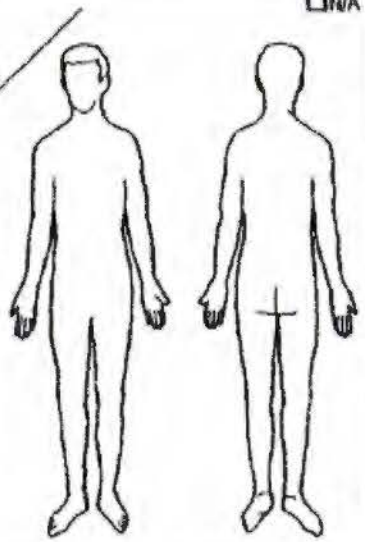
CPR Start Time _____ Discontinue _____ Witnessed Arrest ☐ Yes ☐ No Time _____ ☐ N/A

Ambulance Run Report – Example (Con't)

PHYSICAL EXAMINATION

Physical Examination — ☐ N/A

Injury / Pain Location	Pain (No Trauma)	Blunt	Dis / FX	Gunshot	Laceration / Abrasion	Puncture / Stab	Soft Tissue Swelling	Burn	
Head / Face									
Neck									
Chest / Axilla									
Abdomen									
Back / Flank									
Pelvis / Hip									
L Arm U L J									
R Arm U L J									
L Leg U L J									
R Leg U L J									



Glasgow Coma Scale

		Scene	Enroute
A.	Eye Opening		
	Spontaneous	4	4
	To voice	3	3
	To pain	2	2
	None	1	1
B.	Verbal Response		
	Oriented	5	5
	Confused	4	4
	Inappropriate words	3	3
	Incomprehensible Words	2	2
	None	1	1
C.	Motor Response		
	Obeys commands	6	6
	Purposeful movement	5	5
	Withdraws to pain	4	4
	Flexion to pain	3	3
	Extension to pain	2	2
	None	1	1

Time _____

A. + B. + C. = _____ _____ ☐ N/A

TRAUMATIC INJURY

Motor Vehicle Crash ☐ N/A

P = Patient Location in Vehicle
X = Location of Damage to Vehicle

Type ☐ N/A
- ☐ Car ☐ Motorcycle
- ☐ Truck ☐ ATV
- ☐ Van ☐ Snowmobile
- ☐ Semi ☐ Watercraft
- ☐ Bus ☐ Aircraft

Exterior Damage ☐ N/A
- ☐ None
- ☐ Minor
- ☐ Moderate
- ☐ Major
- ☐ Rollover

Interior Damage ☐ N/A
- ☐ None
- ☐ Splintered Window
- ☐ SL Wh. Bent
- ☐ Compart. Intrusion
- ☐ Patient Ejected

Restraints ☐ N/A

	Obs	Rprt
Airbag	☐	☐
Lap Belt	☐	☐
Shoulder Belt	☐	☐
Child Seat	☐	☐

Safety Equipment ☐ N/A
- ☐ None
- ☐ Helmet
- ☐ Eye Prot.
- ☐ Prot. Clothing
- ☐ Float. Dev.
- ☐ Unknown

Cause of Injury ☐ N/A
- ☐ Aircraft Related
- ☐ Athletic Event
- ☐ Bicycle Crash
- ☐ Bite
- ☐ Chemical Exposure
- ☐ Child Battering Suspected
- ☐ Drowning
- ☐ Drug Ingestion
- ☐ Electrocution (Non-Light.)
- ☐ Excessive Cold
- ☐ Excessive Heat
- ☐ Fall
- ☐ Fire / Flames
- ☐ Firearm Self-Inflicted
- ☐ Firearm Accidental
- ☐ Firearm Assault
- ☐ Lightning
- ☐ Machinery Injury
- ☐ Mechanical Suffocation
- ☐ Motor Vehicle (Non-Traff.)
- ☐ Motor Vehicle (Traffic)
- ☐ Pedestrian Traffic
- ☐ Physical Assault
- ☐ Poison, Not Drugs
- ☐ Radiation Exposure
- ☐ Sexual Assault
- ☐ Smoke Inhalation
- ☐ Stabbing
- ☐ Stings (Plant / Animal)
- ☐ Water Transport Incident
- ☐ Unknown
- ☐ Other _____

Ambulance Run Report – Example (Con't)

Provider Impression If more than one impression is checked, Circle Primary One

- ☐ Abd. Pn. / Problems
- ☐ Airway Obstruction
- ☐ Allergic Reaction
- ☐ Altered L.O.C.
- ☐ Behavioral / Psych
- ☐ Cardiac Arrest
- ☐ Cardiac Rhythm. Disturb.
- ☐ Chest Pn. Discomfort
- ☐ Congestive Heart Failure
- ☐ Diabetic Symptoms
- ☐ Electrocution
- ☐ GI Bleed
- ☐ Headache
- ☐ Hypertension
- ☐ Hyperthermia / Fever
- ☐ Hypothermia
- ☐ Hypovolemia / Shock
- ☐ Intoxication Suspected / Alcohol Ingestion
- ☐ Obvious Death
- ☐ Poison / Drug Ingestion
- ☐ Pregnancy / Ob Delivery
- ☐ Respiratory Arrest
- ☐ Respiratory Distress
- ☐ Seizure
- ☐ Sexual Assault / Rape
- ☐ Toxic Inhalation
- ☐ Stings / Bites
- ☐ Stroke / CVA / TIA
- ☐ Syncope / Fainting
- ☐ Traumatic Injury
- ☐ Vaginal Hemorrhage
- ☐ Unknown
- ☐ Other _____

COMMENT

Chief Complaint / Mechanism of Injury:

Time of Onset:

Comments:

Procedure or Treatment	EMT	EMT
☐ Assisted Ventilation		
☐ Backboard		
☐ Bleeding Control		
☐ Burn Care		
☐ CPR		
☐ Cervical Immobilization		
☐ DNR Protocol		
☐ Glucose Administration		
☐ Nasopharyngeal Airway		
☐ Obstetric Care / Delivery		
☐ Oropharyngeal Airway		
☐ O2 By Mask _____ liters		
☐ O2 By Cannula _____ liters		
☐ Physical Exam		
☐ Radio / Phone Report		
☐ Splint of Extremity		
☐ Traction Splint		
☐ Vital Signs		
☐ OTHER: _____		
☐ None		

If an advanced skill is performed, complete form DPH 7300

MISCELLANEOUS

Incident Disposition

☐ Treated / Transported by EMS

Destination Type - AND - Destination Determination

- ☐ Home / Residence
- ☐ Police / Jail
- ☐ Medical Office / Clinic
- ☐ Skilled Nursing Facil.
- ☐ Hospital Direct Admit
- ☐ Hospital ED
- ☐ Morgue
- ☐ Other
- ☐ Closest Facility
- ☐ Diversion
- ☐ EMT Choice
- ☐ Law Enforce. Choice
- ☐ Managed Care
- ☐ On Line Med. Direction
- ☐ Patient / Family Choice
- ☐ Patient / Phys. Choice
- ☐ Protocol
- ☐ Specialty Center
- ☐ Other

☐ Treated / Transferred Care

- ☐ To Aero-Medical Unit
- ☐ To ALS Unit
- ☐ To BLS Unit
- ☐ To Law Enforcement

☐ Treated / No Transport

- ☐ Treat. / Trans. by Priv. Veh.
- ☐ Treat. / Trans. by Other Means
- ☐ Treated and Released
- ☐ Patient Refused Care

- ☐ No Treat. Needed
- ☐ Dead at Scene
- ☐ Cancelled
- ☐ Unknown
- ☐ No Patient Found

Lights And Siren During Transport: ☐ N/A

- ☐ Non-Emergent, No Lights or Siren
- ☐ Emergent, Lights and Siren
- ☐ Initial Emergent, Downgrade To No Lights and Siren
- ☐ Initial Non-emergent, Upgrade To Lights and Siren

Patient Transported

- ☐ Prone
- ☐ Supine
- ☐ Sitting
- ☐ Patient Restrained
- ☐ Head Elevated
- ☐ Feet Elevated
- ☐ In _____ Lateral Position
- ☐ Other

Other Services on Scene

- ☐ Law Enforcement _____
- ☐ Fire _____
- ☐ Other _____
- ☐ None
- ☐ Physician
- ☐ First Responder _____
- ☐ Nurse / Physician Assistant

☐ N/A

Arrival Status ☐ N/A

- ☐ Unchanged
- ☐ Better
- ☐ Worse
- ☐ DOA
- ☐ Unknown

PPE Used ☐ N/A

- ☐ Gloves
- ☐ Gown
- ☐ Goggles
- ☐ Mask
- ☐ Other _____

Facility Notified By ☐ N/A

- ☐ Radio
- ☐ Phone
- ☐ Unable*
- ☐ No Need*
- ☐ Direct
- ☐ EKG Telemetry

*Explain _____

Difficulties Encountered

- ☐ Dispatch ☐ Other _____
- ☐ Extrication
- ☐ Hazardous Material
- ☐ Language Barrier
- ☐ Road
- ☐ Unsafe Scene
- ☐ Vehicle Problems
- ☐ Weather

☐ N/A

Time Report Received: By:

Report Given To: ☐ N/A

EMT Signature

Objective 3:

Describe the "how to" steps to find OMHA relevant information in a medical file.

Suggested Order of OMHA Review

- Discharge Summary
- History and Physical
- Operative Report
- Physician Orders and Progress Notes

Suggested Order of OMHA Review

- Case Specific Records:
  - Emergency Department and Ambulance Record
  - Nursing and Therapy Notes
  - Medication Record

Normal Vital Signs - Range

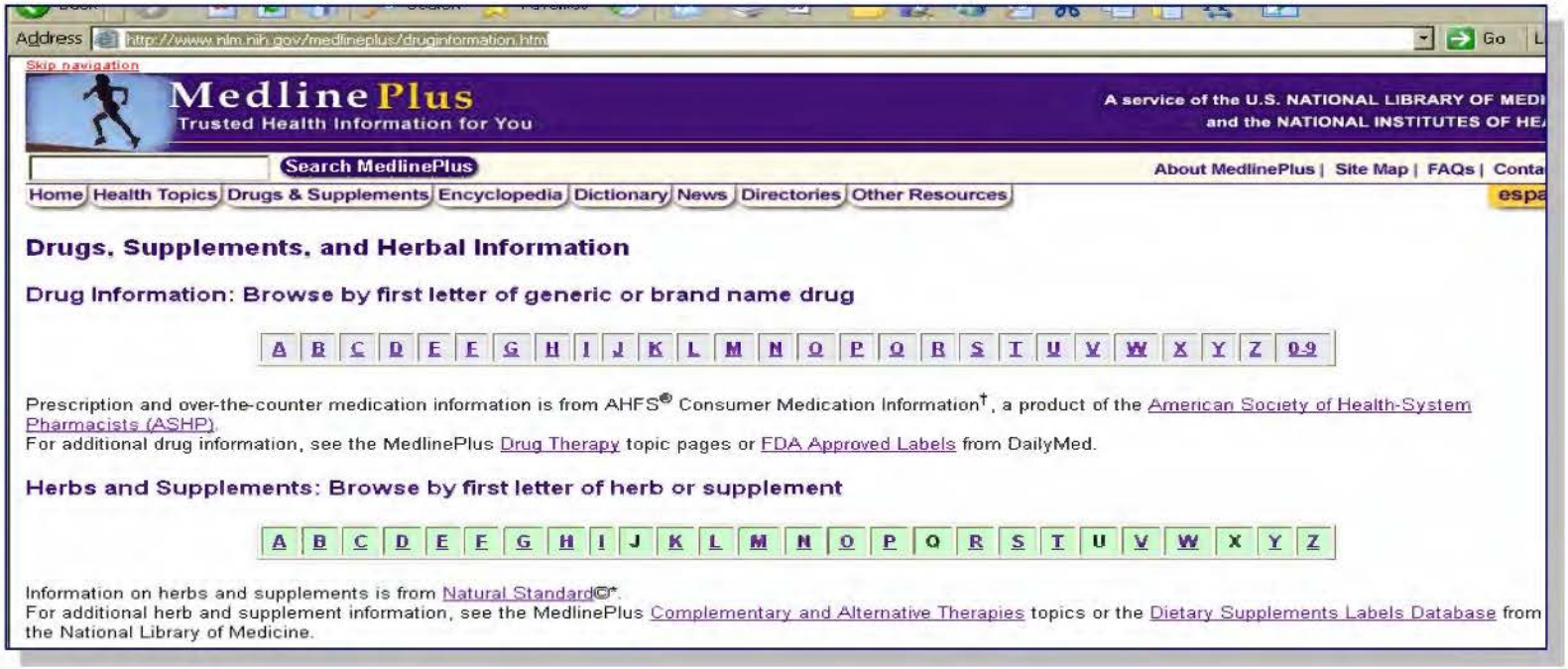
- Temperature
  - Oral 98.6° Fahrenheit (Range of 97.5° to 99.5°)
  - 37° Celsius (Range 36° to 37.9°)
- Blood Pressure
  - Systolic – 100-120 mmHg
  - Diastolic – 80 or below mmHg

Normal Vital Signs - Range

- Resting Heart Rate
  - 60-100 BPM
- Respirations
  - 16-20 /min at rest
  - Babies – 40-90/min

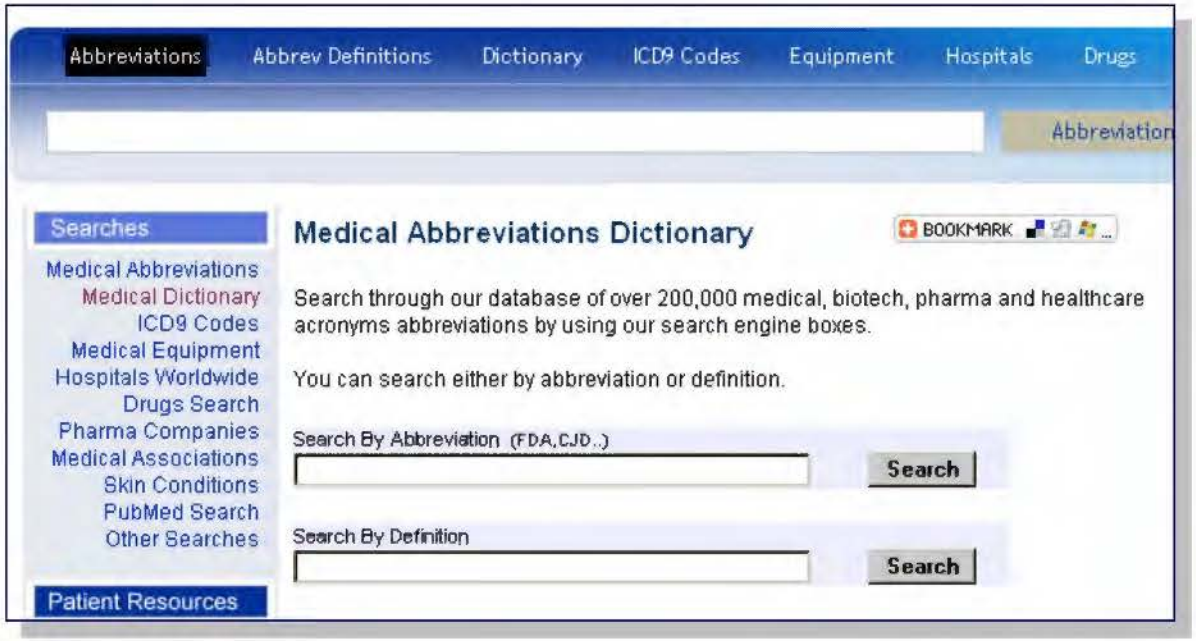
Medication Reference

- Medline Plus
  - http://www.nlm.nih.gov/medlineplus/druginformation.html



Medical Abbreviations

- http://www.globalrph.com/abbrev.htm
- http://www.medilexicon.com/medicalabbreviations.php



Questions

Module 17
Inpatient Hospitalization

Inpatient vs. Outpatient

- Medicare: inpatient vs. outpatient
- Distinction primarily relates to the level of care and services the physician determines the patient requires at the time of admission.

Reconsideration Denial Reason(s)

- The inpatient hospitalization services at issue were not reasonable and medically necessary.

- The beneficiary must demonstrate signs and symptoms severe enough to warrant medical care and must receive services of such intensity that they could be furnished safely and effectively only on an inpatient basis.

Reconsideration Denial Reason(s)

- The documentation submitted for review did not support that the beneficiary required an inpatient level of care.
- The procedure rendered is generally performed as an outpatient procedure unless complications occur beyond twenty-four hours of observational care.
- There is no clear documentation in the chart that the attending physician expected the beneficiary to require hospital care to span two midnights.

Documentation/Evidence

- Physician progress notes
- Nursing/professional notes
- Physician's orders - signed and dated
- Diagnostic Test Results
- History and Physical
- Discharge Summary

Compare Evidence to Coverage

- The severity of the signs and symptoms exhibited by the patient;
- The medical predictability of something adverse happening to the patient;
- The need for diagnostic studies that take less than 24 hours to complete to assist in assessing whether the patient should be admitted; and
- The availability of diagnostic procedures.

Medicare Benefit Policy Manual (MBPM) (Internet-only Manual Publ'n 100-02) ch. 1, § 10.

Compare Evidence to Coverage

Minor Surgery or Other Treatment:

- Known diagnoses;
- Specific minor surgical procedure or other treatment;
- Hospitalization is expected to be less than 24 hours; and
- They are considered outpatients for coverage purposes regardless of the hour they came to the hospital, whether they used a bed, and whether they remained in the hospital past midnight.

MBPM, ch. 1, § 10

Compare Evidence to Coverage

Beneficiaries can have a complicated medical history involving numerous medical conditions, *i.e.*, arteriosclerotic heart disease, ischemic cardiomyopathy, hypertension, hyperlipidemia, diabetes and renal insufficiency.

However, if the pre-procedure order was for outpatient hospitalization and the beneficiary has the scheduled cardiac procedure which is normally performed in an outpatient context – it is generally outpatient.

Two-Midnight Rule (October 2013)

- Presumption: Hospital stays spanning two or more midnights after formal admission are reasonable and necessary; generally not subject to review (audit).

- Benchmark: Payable under Part A if an MD admits a beneficiary with a reasonable expectation that hospital care will cross two midnights.

- Admissions shorter than two midnights (that did not involve the provision of inpatient-only procedures) generally should have been provided on outpatient basis unless clear in the record that the MD expected the beneficiary to require care spanning two midnights even though that did not occur.

Two-Midnight Rule (2015)

- Added additional exceptions to the two-midnight rule on a "case-by-case basis" as long as the decision is supported by the documentation.
- The starting point for the two midnight timeframe for medical review purposes is when the beneficiary starts receiving medical services following arrival at the hospital.
- QIOs rather than RACs perform medical reviews and probe and educate responsibilities for stays affected by the two-midnight rule.

Minor Surgical Procedures

- It is rare and unusual for a stay of 0 or 1 midnights, for patients with known diagnoses entering a hospital for a specific minor surgical procedure or other treatment that is expected to keep them in the hospital for less than 2 midnights, to be appropriately classified as inpatient and paid under Medicare Part A.

- The underlying need for medical or surgical care at the hospital must be documented and supported by complex medical factors or other unforeseen circumstances.

- Another exception would be services on the inpatient-only list.

Delays Providing Care

- Hospital care that is custodial, rendered for social purposes or reasons of convenience, and is not required for the diagnosis or treatment of illness or injury, should be excluded from Part A payment.

CMS, *Medicare Program Integrity Manual (Internet-only Manual Publ'n 100-08)* ch. 6, § 6.5.2.

Burden of Proof

Pursuant to section 1815(a) of the Act, no payment shall be made to any provider unless it has furnished the information in order to determine the amounts due.

Questions

- CMS
- Other Judges
- GS-14 Attorney
- Senior Attorneys
- Attorneys
- OMHA Program Evaluation and Policy Division

Module 18: Inpatient Rehabilitation Facility (IRF) Services

Objectives

At the completion of this lesson, you will be able to:

1. Learn what is the Inpatient Rehabilitation Facility (IRF) Benefit;

2. Understand Medicare coverage requirements for IRF Services;

Objectives (cont'd)

At the completion of this lesson, you will be able to:

3. Understand Medicare documentation requirements for IRF Services; and

4. Understand that different CMS guidelines and requirements were in effect for IRF services with discharge dates prior to January 1, 2010.

The IRF Benefit

Designed to provide:

- Intensive rehabilitation therapy
- In a resource intensive hospital environment
- For patients who require, and are reasonably expected to benefit from, an inpatient stay and interdisciplinary approach to the delivery of rehabilitation care

Medicare Benefits Policy Manual (MBPM) (Internet-only Manual Publ'n 100-02) ch. 1, § 110

Timing of IRF Referral

- Patients who are still completing their course of treatment in the referring hospital and cannot tolerate an intensive therapy program are not appropriate for IRF admission.

Timing of IRF Referral (cont'd)

- Patients must be able to fully participate in and benefit from intensive rehabilitation therapy program prior to transfer from the referring hospital.

Common Reasons for Denials

- Patient does not require active and ongoing therapeutic intervention of multiple disciplines
- Documentation does not support medical necessity
- Missing, incomplete, or illegible signatures

Medicare Part A
Basic Criteria for IRF Services

The patient must meet all of the requirements set forth in 42 C.F.R. §§ 412.622(a)(3),(4) and (5).

CMS, *Medicare Benefits Policy Manual (MBPM)(Internet-Only Manual Publ'n 100-2)* ch. 1 § 110, also outlines the basic coverage criteria for IRF services.

Medicare Part A
Basic Criteria for IRF services (cont'd)

- **Coverage Requirements -** 42 C.F.R. § 412.622(a)(3); *MBPM, supra*, ch. 1, § 110.2

- **Interdisciplinary Team Approach to Care -** 42 C.F.R. § 412.622(a)(5); *MBPM, supra*, ch. 1, § 110.2.5

Medicare Part A
Basic Criteria for IRF services (cont'd)

- **Documentation Requirements -** 42 C.F.R. § 412.622(a)(4); *MBPM, supra*, ch. 1, § 110.1

- **Coverage Requirements** - 42 C.F.R. § 412.622(a)(3); *MBPM, supra*, ch. 1, § 110.2

IRF Coverage Requirements

The patient must require active and ongoing therapeutic intervention of multiple therapy disciplines (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics therapy), one of which must be physical or occupational therapy.

IRF Coverage Requirements (cont'd)

The patient must require intensive therapy program, generally consisting of at least 3 hours of therapy per day, at least 5 days a week, **or** at least 15 hours in a consecutive 7-day period.

The intensity of therapy provided must be reasonable and necessary under section 1862(a)(1)(A) of the Act.

IRF Coverage Requirements (cont'd)

Note: On October 17, 2017, CMS issued a technical direction letter, clarifying that IRF claims should not be denied solely because the threshold of therapy time is not met. Rather, the claim should undergo further medical review using clinical judgment to determine medical necessity **based on the individual facts and circumstances of the case**.

IRF Coverage Requirements (cont'd)

Patient must be able to actively participate in intensive rehabilitation therapy program and benefit from it.

The patient must require supervision by a rehabilitation physician, conducting face-to-face visits with the patient at least 3 days per week.

Interdisciplinary Team Approach to Care

42 C.F.R. § 412.622(a)(5);
MBPM, supra, ch. 1, § 110.2.5

Interdisciplinary Team Approach to Care

- The patient must require an intensive and coordinated interdisciplinary approach to providing rehabilitation.
- The purpose of an interdisciplinary team approach is to foster frequent, structured, and documented communication among disciplines to establish, prioritize, and achieve treatment goals.

Interdisciplinary Team Approach to Care

(cont'd)

Interdisciplinary Team Includes:

- At least a rehabilitation physician, a registered nurse, a social worker or a case manager, and a licensed therapist from each therapy discipline involved in treating the patient.

Interdisciplinary Team Approach to Care

(cont'd)

- Interdisciplinary team conferences must be held, at a minimum, **once per week**.
- Notes must document participation by professionals from each of the interdisciplinary team members.

Interdisciplinary Team Approach to Care

(cont'd)

Periodic team conferences—held a minimum of once per week—must focus on:

- Assessing the individual's progress towards the rehabilitation goals;
- Considering possible resolutions to any problems that could impede progress towards the goals;

Interdisciplinary Team Approach to Care (cont'd)

- Reassessing the validity of the rehabilitation goals previously established; and

- Monitoring and revising the treatment plan, as needed.

Medicare Part A
Basic Criteria for IRF Services

Documentation Requirements

42 C.F.R. § 412.622(a)(4);
MBPM, supra, ch. 1, § 110.1

Documentation Requirements

- Preadmission Screening
- Post-Admission Physician Evaluation

Documentation Requirements (cont'd)

- Individualized Overall Plan of Care
- Admission Orders
- Patient Assessment Instrument (IRF-PAI)

Preadmission Screening

The preadmission screening is an evaluation of the patient's condition and need for rehabilitation therapy and medical treatment.

The preadmission screening must be completed by licensed or certified clinician within 48 hours immediately preceding the IRF admission.

Preadmission Screening (cont'd)

Must include:

- The specific reasons that led the IRF clinical staff to conclude an IRF admission would be reasonable and necessary;
- The patient's prior level of function;
- The patient's expected level of improvement;

Preadmission Screening (cont'd)

Must include:

- The expected length of time necessary to achieve the expected level of improvement;
- An evaluation of the patient's risk for clinical complications;

Preadmission Screening (cont'd)

Must include:

- Conditions that caused the need for rehabilitation;
- Treatments needed (OT, PT, SLP, or prosthetics/orthotics);

Preadmission Screening (cont'd)

Must include:

- The expected frequency and duration of treatment in the IRF;
- The anticipated discharge destination;
- Any anticipated post-discharge treatment; and
- Any information relevant to the care needs of the patient.

Preadmission Screening (cont'd)

A rehabilitation physician must document that he or she reviewed and concurred with the findings and results of the preadmission screening prior to the IRF admission.

Post-Admission Physician Evaluation

- Must be completed within 24 hours of IRF admission;
- Must be performed by a rehabilitation physician;

Post-Admission Physician Evaluation (cont'd)

- Must begin development of the patient's expected course of treatment that will be completed with input from all of the interdisciplinary team members in the overall plan of care;

Post-Admission Physician Evaluation (cont'd)

- Must identify any relevant changes since the preadmission screening;
- Must document patient's status at time of admission and include comparison with information noted in preadmission screening;

Post-Admission Physician Evaluation (cont'd)

- Must include history and physical exam, review of patient's prior and current conditions, comorbidities; and

- Must support the IRF admission is reasonable and necessary.

Individualized Overall Plan of Care

- Must be completed within four days of IRF admission;
- Must detail the patient's medical prognosis; anticipated interventions, functional outcomes, and discharge destination; and
- Expected intensity, frequency, and duration of therapy.

Admission Orders

A physician must generate admission orders for each IRF admission at the time of admission.

The admission orders must be retained in the patient's medical records.

Admission Orders (cont'd)

The order must comply with signature requirements set forth in the CMS *Medicare Program Integrity Manual (MPIM)(Internet-Only Manual, Publ'n 100-8)* ch. 3, § 3.3.2.4.

Patient Assessment Instrument (IRF-PAI)

IRF-PPS (prospective payment system) is based on the information found in the IRF-PAI.

IRF-Patient Assessment Instrument (PAI)

An IRF-PAI includes patient's clinical, demographic, and other information used to classify what the patient's expected resource needs would be.

IRF-Patient Assessment Instrument (PAI)

The CMS Website includes these useful tools:

IRF-PAI Training Manual

- IRF-PAI form (version 1.5), effective October 1, 2017

- IRF-PAI form (version 2.0), effective October 1, 2018

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/IRFPAI.html

Summary

Patient must meet all of the requirements outlined in 42 C.F.R. §§ 412.622(a)(3), (4) and (5).

- **Coverage Requirements** 42 C.F.R. § 412.622(a)(3); MBPM, ch. 1, § 110.2,
- **Documentation Requirements** 42 C.F.R. § 412.622(a)(4); MBPM, ch. 1, § 110.1, and

Summary (cont'd)

- **Interdisciplinary Team Approach to Care** 42 C.F.R. § 412.622(a)(5); MBPM, ch. 1, § 110.2.5.

IRF Discharges Prior to January 1, 2010

- In August 2009, CMS issued a final rule adopting new IRF coverage criteria, effective for IRF discharges on or after January 1, 2010.
- For IRF services with discharge dates prior to January 1, 2010, different coverage requirements were in place.

IRF Services with Discharges Prior to 2010

Pre-2010 requirements:

- Close medical supervision by a rehabilitation physician
- 24-hour rehabilitation nursing
- Relatively intense rehabilitation services
- Multi-disciplinary team approach

IRF Services with Discharges Prior to 2010 (cont'd)

Pre-2010 requirements:

- Coordinated Program of Care
- Significant Practical Improvement
- Realistic Goals
- Length of Rehabilitation Program

Other Document Resources

- Inpatient Hospital Discharge Summary;
- Interdisciplinary Team Meeting Notes;
- Physician notes;

Other Document Resources (cont'd)

- Therapy records;
- Rehabilitation Nursing records;
- Discharge Summary –*previously included in* CMS, *Medicare Benefit Policy Manual (MBPM) (Internet-Only Manual Publ'n 100-2)* ch. 1, § 110.3.

Module Review

Now that you have completed this module, you should be able to:

- ✓Understand what Inpatient Rehabilitation Facility (IRF) Services are;
- ✓Understand Medicare coverage requirements for IRF Services;

Module Review (cont'd)

- ✓Understand Medicare documentation requirements for IRF Services; and
- ✓Understand that different CMS guidelines and requirements were in effect for IRF services with discharge dates prior to January 1, 2010.

Module 19
Post-Hospital Extended Care Skilled Nursing Facility (SNF) Services

Lesson Objectives (1-2)

- Understand the law applicable to SNF appeals;
- Understand how to approach a SNF appeal;
- Understand the CMS SNF PPS and the relationship between the MDS and the RUG codes used for SNF PPS billing;

Lesson Objectives (2-2)

- Understand the impact of Consolidated Billing for SNF claims; and
- Understand SNF Liability and Termination of Coverage Issues.

Law and Authority

- The Social Security Act (the Act) defines "Post-Hospital Extended Care Services" and "Extended Care Services." Act §§ 1861(h)-(i).
- Medicare Part A beneficiaries are entitled to payment for post-hospital extended care services, i.e., post-hospital SNF care. Act § 1812(a)(2)(A).
- As a condition of Medicare Part A payment, SNF services are subject to certification requirements. Act § 1814(a)(2)(B).

What is Medicare's SNF Benefit?

- Medicare covers necessary post-hospital extended care services for up to 100 days.
- Extended care services are nursing care and rehabilitation services provided to a beneficiary who is an inpatient in a SNF.

What is covered under the SNF benefit?

- Medicare covers nursing services, bed and board, rehabilitation services, social services, drugs, biologicals, supplies, appliances, and equipment.
- Medicare does **not** cover custodial care, and services specifically excluded from consolidated billing.

What requirements need to be satisfied for coverage/payment of SNF services?

- Technical Eligibility Requirements
- Level of Care Requirements
- Certification Requirements

Technical Eligibility Requirements

- The beneficiary must be enrolled in Medicare Part A and have days available to use.
- There has been a 3-day prior qualifying hospital stay (excluding day of hospital discharge).
- Admission for SNF-level services is within 30-days of discharge from acute care or SNF (or qualify for an exception).

42 C.F.R. § 409.30.

Level of Care (LOC) Requirements (1-2)

- Must require **skilled care on a daily basis**
- Which, as a **practical matter**, can only be provided in a SNF

Level of Care (LOC) Requirements (2-2)

- The services provided **must be for a condition**:
  - For which the resident was treated during the qualifying hospital stay, **or**
  - That arose while a resident in the SNF for treatment of a condition for which he/she was previously treated for in a hospital.

42 C.F.R. § 409.31(b).

LOC Requirement – Skilled Care (1-4)

"Skilled Care" —

- Services ordered by a physician;
- Which require the skills of technical or professional personnel (e.g., RN, LPN, physical therapist); and
- Are furnished directly by, or under the supervision of, such personnel.

42 C.F.R. § 409.31(a).

LOC Requirement – Skilled Care (2-4)

"Skilled Care" —

- Services so inherently complex that they can be safely and effectively performed only by, or under the supervision of, professional or technical personnel

42 C.F.R. § 409.32(a).

LOC Requirement – Skilled Care (3-4)

- Services that, although may not normally be considered skilled, may be considered skilled if the patient's condition and complications require performance by skilled personnel

42 C.F.R. § 409.32.

LOC Requirement – Skilled Care (4-4)

"Daily basis" -

- Must be needed and provided 7 days a week.
- If skilled rehabilitation services are not available 7 days a week, then must be needed and provided at least 5 days a week.

42 C.F.R. § 409.34(a).

Level of Care Requirements –Practical Matter

- Even if the beneficiary is receiving daily skilled care, that care must be such that, as a practical matter, it can only be provided in a SNF, on an inpatient basis. 42 C.F.R. § 409.31(b)(3).
- Consideration must be given to the patient's condition, and to the availability and feasibility of using more economical alternative facilities and services. 42 C.F.R. § 409.35(a).

LOC Requirement – Skilled Care

Need is not based on restoration potential

- Restoration potential of the patient is not a deciding factor. Even if full recovery or medical improvement is not possible, a patient may need skilled services to prevent further deterioration or preserve current capabilities.

42 C.F.R. § 409.32(c).

LOC Requirement – Case Review (1-2)

SNF documentation should enable a reviewer to determine whether—

- Skilled involvement is required in order for the services in question to be furnished safely and effectively; and
- The services themselves are, in fact, reasonable and necessary for the treatment of a patient's illness or injury.

LOC Requirement – Case Review (2-2)

- The documentation must also show that the services are appropriate in terms of duration and quantity, and that the services promote the documented therapeutic goals.

CMS, *Medicare Benefits Policy Manual (MBPM) (Internet-only Publ'n 100-02)* ch. 8, § 30.2.2.1.

Technical/LOC Requirements – Summary (1-2)

- There is a qualifying three-day hospital stay,
- The post-hospital transfer to SNF made within 30 days after leaving the hospital,
- The patient has not exhausted the 100 benefit period,

Technical/LOC Requirements – Summary (2-2)

- The patient requires and receives skilled care on a daily basis,
- The skilled care provided is related to the condition for which patient was hospitalized,
- The services, as a practical matter, must be required to be provided on an inpatient basis.

Certification Requirements

- A physician must certify that that individual requires skilled care which can only be provided by a SNF. Act § 1814(a)(2)(B); 42 C.F.R. § 424.20.
- Certification is a basic condition for payment. 42 C.F.R. § 424.5(a)(4).
- The provider SNF responsibility to obtain the necessary certification and re-certification statements. Act § 1866; 42 C.F.R. § 424.11.

Certification Requirements - Timing

- Initial Certification - At the time of admission, or as soon thereafter as reasonable. 42 C.F.R. § 424.20(b).
- First Recertification – no later than 14th day of SNF care. 42 C.F.R. § 424.20(d)(1).
- Subsequent Recertifications – Every 30 days. 42 C.F.R. § 424.20(d)(1).

Certification Requirements - Content

- The need for daily skilled nursing care or skilled rehabilitation services which, as a practical matter, can only be provided in an SNF on an inpatient basis, and SNF care is needed for a condition for which the individual received inpatient hospital care in a participating hospital or
- The beneficiary has been correctly assigned into one of the Resource Utilization Groups (RUGs) as representing the required level of care

42 C.F.R. § 424.20(a).

Certification Requirements – Recertification (1-2)

- Reason for the continued need for SNF care
- The estimated duration of SNF care
- Plans for home care, if any, and

Certification Requirements – Recertification (2-2)

- If appropriate, the continued services are needed for a condition that arose after admission to the SNF, and while the beneficiary was still under treatment for the condition related to inpatient hospital services

42 C.F.R. § 424.20(c).

Certification Requirements - Signature

A certification or recertification statement must be signed by the **attending physician** or by a **physician extender** who does not have a direct or indirect employment relationship with the facility, but who is working in collaboration with the physician.

42 C.F.R. § 424.20(e).

Certification Requirements

If the SNF's failure to obtain a certification or recertification is not due to a question of the necessity for the services, but to the physician's or physician extender's refusal to certify on other grounds, the SNF cannot charge the beneficiary for covered items or services. Its provider agreement precludes it from doing so.

MBPM, supra ch. 8, § 40.1; Act § 1866; 42 C.F.R. § 489.21.

SNF Requirements - Review

- Technical Eligibility Requirements
- Level of Care Requirements
- Certification Requirements

SNF Liability (1-2)

Technical Requirements not met = no application of limitation on liability provisions.

- Limitation on liability provisions do apply when services are:
  - Not medically reasonable and necessary. Act § 1862(a)(1)(A).
  - Custodial in nature. Act § 1862(a)(9).

IF limitation on liability provisions apply, a SNF must provide a beneficiary with a SNF Advanced Beneficiary Notice (SNFABN).

SNF Liability (2-2)

Waiver and/or assignment of liability for non-covered SNF services hinges on whether the beneficiary and/or provider knew, or could have reasonably been expected to know, the services would be excluded from Medicare coverage. Act § 1879; 42 C.F.R. §§ 411.400-406.

- Beneficiary requires written notice of non-coverage. 42 C.F.R. § 411.404.
- Provider assumed to have knowledge based on experience, actual notice, or constructive notice. 42 C.F.R. § 411.406.

Liability

Resources for liability issues:

- CMS, *Medicare Claims Processing Manual (Internet-only Manual Publ'n 100-04)* ch. 30, § 70.
- CMS Ruling 95-1.

PROSPECTIVE PAYMENT SYSTEM (PPS) (1-10)

Medicare covered SNFs are reimbursed under a prospective payment system (PPS). The SNF PPS reimburses providers a daily amount after adjusting for urban/rural, case-mix, and area wage differences.

- PPS covers most costs associated with furnishing SNF services to Medicare beneficiaries.
- PPS requires the use of consolidating billing.

Act § 1888(e); 42 C.F.R. § 413.330.

Prospective Payment System (PPS) (2-10)

Every SNF Medicare claim must include an assessment date and a five-position Health Insurance Prospective Payment System (HIPPS) code.

- First 3 positions—Resource Utilization Group (RUG) code to be billed for Medicare reimbursement.

Prospective Payment System (PPS) (3-10)

Last 2 positions—Represent the Assessment Indicator (AI) which identifies the reason and timeframe for completion of the MDS

Example: RVB30

Prospective Payment System (PPS) (4-10)

- The current RUG-IV classification system has 66 different groups with 10 major categories.
- The information used to assign a beneficiary a RUG is gathered from the Minimum Data Set (MDS). The MDS is one of three components of the Resident Assessment Instrument (RAI).

Prospective Payment System (PPS) (5-10)

RUG-IV GROUP CODES:

- **Rehabilitation Plus Extensive Services:** RUX, RUL, RVX, RVL, RHX, RHL, RMX, RML, RLX
- **Rehabilitation:** RUA, RUB, RUC, RVA, RVB, RVC, RHA, RHB, RHC, RMA, RMB, RMC, RLA, RLB
- **Extensive Services:** ES3, ES2, ES1

Prospective Payment System (PPS) (6-10)

- **Special Care High:** HE2, HE1, HD2, HD1, HC2, HC1, HB2, HB1
- **Special Care Low:** LE2, LE1, LD2, LD1, LC2, LC1, LB2, LB1
- **Clinically Complex:** CE2, CE1, CD2, CD1, CC2, CC1, CB2, CB1, CA2, CA1
- **Behavioral Symptoms and Cognitive Performance:** PE2, PE1, PD2, PD1, PC2, PC1, PB2, PB1, PA2, PA1

Prospective Payment System (PPS) (7-10)

Table 6-2
Assessment Indicator First Digit Table

1st Digit Values	Assessment Type (abbreviation)	Standard* Scheduled Payment Period
0	Unscheduled PPS assessment (unsched)	Not applicable
1	PPS 5-day or readmission return (5d or readm)	Day 1 through 14
2	PPS 14-day (14d)	Day 15 through 30
3	PPS 30-day (30d)	Day 31 through 60
4	PPS 60-day (60d	Day 61 through 90
5	PPS 90-day (90d)	Day 91 through 100
6	OBRA assessment used for PPS (Not combined with any PPS assessment) when Part A eligibility unknown at time of assessment	Not applicable

Prospective Payment System (PPS) (8-10)

SNFs are required to complete RAIs, including the MDS assessments, on or about the 5th day, 14th day, 30th day, 60th day, and 90th day of the SNF stay.

Information contained in the MDS assessments is gathered from applicable "look back" periods (e.g., seven days for rehabilitation services).

42 C.F.R. § 413.343.

Prospective Payment System (PPS) (9-10)

Level of Care Presumption

Under the SNF PPS, beneficiaries who are admitted directly to a SNF after a qualifying hospital stay are considered to meet the level of care requirements of 42 C.F.R. section 409.31 -

Prospective Payment System (PPS) (10-10)

- up to and including the **Assessment Reference Date (ARD)** for the 5-day assessment prescribed in 42 C.F.R. section 413.343(b), when correctly assigned to one of the **Resource Utilization Groups (RUGs)** that is designated as representing the required level of care.

MBPM, supra ch. 8, § 30.1.

Consolidated Billing (1-5)

- Implementation
- Exclusions

Consolidated Billing (2-5)

Consolidated Billing is required under section 4432(b) of the Balanced Budget Act of 1997 (BBA).

Consolidated Billing (3-5)

Why Consolidated Billing?

- Eliminates potential for duplicate (Parts A/B) billing;
- Lessens out-of-pocket beneficiary liability for the Part B deductible; and
- Avoids dispersal of responsibility for resident care among various outside suppliers, which adversely affected quality (coordination of care) and program integrity.

Consolidated Billing (4-5)

Services <u>included</u> in Consolidated Billing:

- Semi-private room, meals, skilled nursing care; PT, OT, SLP, MSW, medications, medical supplies and equipment, ambulance transportation, dietary counseling.

See 42 C.F.R. §§ 409.20–409.27.

Consolidated Billing (CB) (5-5)

Services excluded from CB include:

- Physician's professional services;
- Certain dialysis-related services;
- Certain ambulance services;
- Certain chemotherapy drugs and chemotherapy administration services; and
- Hospice care.

Overview of SNF

- SNF must have complied with MDS assessment schedule. 42 C.F.R. § 413.343.
- Level of Care requirement must be met. 42 C.F.R. § 413.343.
- SNF services must not be statutorily excluded.
- SNF services must be certified by a physician.
- Must be reasonable and necessary. Act § 1862(a)(1)(A).

SNF DOCUMENTATION

- Hospital Discharge Summary
- SNF Admission Notes
- Physician Orders
- Nursing Progress Notes
- Physician Certification(s)
- Therapy Records
- MDS Assessment
- SNFABN/Notice of Non-Coverage

Summary (1-2)

Now that you have completed this lesson, you should be able to:

- Understand the law applicable to SNF appeals;
- Understand how to approach a SNF appeal;
- Understand the CMS SNF PPS and the relationship between the MDS and the RUG codes used for SNF PPS billing;

Summary (2-2)

- Understand the impact of Consolidated Billing (CB) for SNF claims; and
- Understand SNF Liability and Termination of Coverage Issues.

Module 20 -
Home Health Services

Home Health Services Objectives

- Identify laws, regulations and CMS policies, applicable to Medicare coverage for home health appeals.
- Understand the 'differences' between home health care under Medicare Part A and Medicare Part B.
- Understand the documentation requirements for home health coverage and payment.

Covered Home Health Services

- Part-time or intermittent skilled nursing services
- Skilled Therapy (physical therapy, speech language pathology and occupational therapy)
- Part-time or intermittent home health aide services
- Medical supplies and durable medical equipment

42 C.F.R. §§ 409.44 and 409.45

Excluded Services

- Drugs and biologicals
- Transportation
- Housekeeping services
- Prosthetic devices.

42 C.F.R. § 409.49

Law, Regulations & Guidance (1-3)

The Social Security Act

- §§ 1812(a)(2) and (3) and 1832(a)(2)(B)– entitlement (Parts A & B)
- §§ 1814(a)(2)(C) and 1835(a)(2)(A) – payment
- § 1861(m) – definition
- § 1879(g)– liability

Law, Regulations & Guidance (2-3)

Regulations

- 42 C.F.R. §§ 409.40-409.50 - Coverage Requirements
- 42 C.F.R. § 410.80 - Medicare Part B
- 42 C.F.R. § 424.22 – Payment Requirements

Law, Regulations & Guidance (3-3)

Medicare Guidance

CMS, *Medicare Benefit Policy Manual (MBPM) (Internet-only Manual Publ'n 100-2)* Chapter 7

42 C.F.R. § 409.48 (1-2)

- Number of allowable visits under Part A. To the extent that all coverage requirements specified in this subpart are met, payment may be made on behalf of eligible beneficiaries under Part A for an unlimited number of covered home health visits. All Medicare home health services are covered under hospital insurance unless there is no Part A entitlement.

42 C.F.R. § 409.48 (2-2)

- (b) *Number of visits under Part B.* To the extent that all coverage requirements specified in this subpart are met, payment may be made on behalf of eligible beneficiaries under Part B for an unlimited number of covered home health visits. Medicare home health services are covered under Part B only when the beneficiary is not entitled to coverage under Part A.

Coverage Requirements

- Home confinement
- Under the care of a physician
- In need of skilled services
- Under a plan of care

Home Confinement (1-12)

The definition of "home confinement" as set forth in section 1814(a)(8) of the Act:

- …[A]n individual shall be considered to be "confined to his home" if the individual has a condition, due to an illness or injury, that restricts the ability of the individual to leave his or her home except with the assistance of another -

Home Confinement (2-12)

- - individual or the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker), or if the individual has a condition such that leaving his or her home is medically contraindicated.

Home Confinement (3-12)

- - While an individual does not have to be bedridden to be considered "confined to his home", the condition of the individual should be such that there exists a normal inability to leave home and, that leaving home requires a considerable and taxing effort by the individual…

Home Confinement (4-12)

An individual does not have to be bedridden to be considered confined to the home

Home Confinement (5-12)

Exceptions:

- May leave home need to receive health care treatment, including regular absences for the purpose of participating in therapeutic, psychosocial, or medical treatment in an adult day-care program that is licensed or certified by a State, or accredited, to furnish adult day-care services

Home Confinement (6-12)

- May leave home if absences are of infrequent or of relatively short duration (ex., to attend a religious service).

Home Confinement (7-12)

The *MBPM* Two Prong Analysis

1)The patient must either:

a) Because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave their place of residence, **or**

Home Confinement (8-12)

b) Have a condition such that leaving his or her home is medically contraindicated.

AND

2) There must exist a normal inability to leave home; **and** leaving home must require a considerable and taxing effort.

Home Confinement (9-12)

Some examples (*See MBPM*, ch. 7, § 30.1):

- A beneficiary who is blind or senile and requires the assistance of another person in leaving their place of residence;
- A beneficiary who has lost the use of their upper extremities and, therefore, is unable to open doors, use handrails on stairways, etc., and requires the assistance of another individual to leave home.

Home Confinement (10-12)

- A beneficiary with a psychological illness that is manifested in part by a refusal to leave home or is of such a nature that it would be considered unsafe for the beneficiary to leave home unattended, even if the beneficiary has no physical limitations.

Home Confinement (11-12)

What is a "Home"?

- The beneficiary must be confined to the home or in an institution that is not a hospital, SNF or nursing facility as defined in §§ 1861(e)(1), 1819(a)(1) or 1919(a)(1) of the Act.

42 C.F.R. § 409.42(e)

Home Confinement (12-12)

- "A patient's residence is wherever he or she makes his or her home. This may be his or her own dwelling, an apartment, a relative's home, a home for the aged, or some other type of institution." (except as per 42 C.F.R. § 409.42(e)).

MBPM, ch. 7, § 30.1.2

Requirements

- Home confinement
- Under the care of a physician
- In need of skilled services
- Under a plan of care

Under the Care of a Physician (1-10)

Beneficiary must be under the care of a physician who establishes the plan of care.

42 C.F.R. § 409.42(b)

Under the Care of a Physician (2-10)

A physician must certify the initial and ongoing need for services:

- Beneficiary is home confined
- Beneficiary requires intermittent skilled services
- A plan of care was established & periodically reviewed

Under the Care of a Physician (3-10)

- Beneficiary is under the care of a physician
- Initial certification performed after a documented face to face encounter by the certifying physician or specified personnel under supervision of physician

42 C.F.R. § 424.22(a)(1)

Under the Care of a Physician (4-10)

Look for:

- Physician's orders for services
- Signature on Certification/Plan of Care
- Concurrent medical records reflecting physician's involvement

Under the Care of a Physician (5-10)

Initial Certification:

- Must be obtained when plan of care established or "as soon thereafter as possible."
- Must be signed and dated by physician who establishes plan of care. (no timeline stated).

42 C.F.R. § 424.22(a)(1)(B)(1)

Under the Care of a Physician (6-10)

Recertification:

- Physician reviews and signs every 60 days.

42 C.F.R. § 424.22(b)

Under the Care of a Physician (7-10)

Face-to-Face Encounter

For services initiated on or after January 1, 2011, there must be documentation that a face-to-face encounter occurred for the primary reason the patient was referred for home health services.

Under the Care of a Physician (8-10)

- - The encounter must occur within 90 days prior to the initiation of home health services, or within 30 days after the start of the services.

42 C.F.R. § 424.22(a)(v)

Under the Care of a Physician (9-10)

- For services initiated in 2011 through 2014, there must also be a brief narrative statement from the physician describing how the clinical findings from the face-to-face encounter support the beneficiary's homebound status and need for skilled services.

MBPM, ch. 7, § 30.5.1 (eff. Jan. 2011)

Under the Care of a Physician (10-10)

- Effective January 2015, the record must include the actual clinical note from the face-to-face encounter, as well as any other supporting documentation from the certifying physician to support the patient's eligibility for home health services. A descriptive narrative statement is no longer required.

MBPM, ch. 7, § 30.5.1.2 (eff. Jan. 2015)

Requirements

- Home confinement
- Under the care of a physician
- In need of skilled services
- Under a plan of care

Skilled Services (1-8)

Skilled services include:

- Intermittent or Part-Time Nursing
- Physical Therapy
- Occupational Therapy
- Speech Language Pathology

42 C.F.R. § 409.44

Skilled Services (2-8)

Dependent Services Include:

- Occupational therapy*
- Home Health Aide
- Medical Social Services

42 C.F.R. § 409.45

Skilled Services (3-8)

Intermittent Nursing

- "Intermittent" essentially means "less than daily"

Skilled Services (4-8)

- § 1861(m) of the Act defines intermittent as skilled nursing care that is either provided or needed on fewer than 7 days each week, or less than 8 hours each day for periods of 21 days or less (with extensions in exceptional circumstances when the need for additional care is finite and predictable).

Skilled Services (5-8)

- A visit should be provided at least once every 60 days.
- Part-Time Nursing
- Nursing seven days a week generally only for no more than three weeks (21 days).
- *See MBPM*, Chapter 7, § 40.1.3

Skilled Services (6-8)

Skilled Nursing

- Detailed guidance in *MBPM*, ch. 7, § 40.1.2
- 42 C.F.R. § 409.44(b)(3)(iii) – The determination of whether skilled nursing care is reasonable and necessary must be based solely upon the beneficiary's unique condition and individual needs, without regard to whether the illness or injury is acute, chronic, terminal, or expected to last a long time.

Skilled Services (7-8)

- *MBPM*, Chapter 7, § 40.1.2.1 - Observation and Assessment – "[w]here a patient was admitted to home health care for skilled observation because there was a reasonable potential of a complication or further acute episode, but did not develop a further acute episode or complication, -

Skilled Services (8-8)

- - the skilled observation services are still covered for three weeks or so long as there remains a reasonable potential for such a complication or further acute episode.

Requirements

- Home confinement
- Under the care of a physician
- In need of skilled services
- Under a plan of care

Under a Plan of Care (1-3)

Plan of Care Requirements:

- Detailed orders
- Physician signature
- Frequency of review in consultation w/HHA personnel (every 60 days)
- Termination – plan considered terminated if beneficiary does not receive at least one covered skilled service in 60-day period

42 C.F.R. § 409.43

Under a Plan of Care (2-3)

- Home health services must be furnished by a participating HHA

  42 C.F.R. § 409.42(e)

Under a Plan of Care (3-3)

Key Documents:

- OASIS Assessments
- Home Health Certification
- Face-to-Face Documentation
- Home Health Plan of Care

SUMMARY - QUESTIONS

You should now be able to:

- Identify the laws and regulations applicable to home health appeals.
- Understand the 'differences' between the Medicare Part A and Medicare Part B regulations.
- Understand the documentation requirements for home health coverage and payment.

Module 21
Part A Hospice

Objectives (1 of 3)

At the completion of this lesson, you will be able to:

- Identify the laws and regulations applicable to hospice care.
- Understand the terminal illness requirement.
- Explain the coverage criteria for hospice care.
- Describe the certification and recertification requirements.

Objectives (2 of 3)

At the completion of this lesson, you will be able to:

- Identify the services covered under the hospice benefit.
- Explain the documentation requirements.
- Understand how the limitation on liability provisions of § 1879 of the Social Security Act (Act) apply to hospice services.

Applicable Statutes

- Act § 1814(a)(7)
- Act § 1812(a)(4)
- Act § 1861(dd)(1)
- Act § 1862(a)(1)(C)
- Act § 1879(g)

Applicable Regulations

42 C.F.R. Part 418

CMS Publications

CMS, *Medicare Benefit Policy Manual (Internet-Only Manual Publ'n 100-2)*, ch. 9

CMS, *Medicare Claims Processing Manual (Internet-Only Manual Publ'n 100-4)*, ch. 11

Eligibility Requirements

42 C.F.R. § 418.20 – In order to be **eligible** to elect hospice care under Medicare, an individual must be:

- Entitled to Medicare Part A; and
- Certified as being terminally ill in accordance with 42 C.F.R. § 418.22.

Definition of Terminal Illness

42 C.F.R. § 418.3 defines the term "terminally ill."

An individual is considered to be terminally ill if the medical prognosis is that the individual's life expectancy is **six months or less** if the illness runs its normal course.

Election of Hospice Care (1 of 3)

42 C.F.R. § 418.24 –

An individual who meets the eligibility requirements of 42 C.F.R. § 418.20 may file an election statement with a particular hospice.

Election of Hospice Care (2 of 3)

42 C.F.R. § 418.24 –

When choosing a particular hospice, the beneficiary waives the right to receive hospice care from another hospice, and any Medicare services that are for the treatment of the terminal illness.

Election of Hospice Care (3 of 3)

42 C.F.R. § 418.24 –

This waiver does not apply to physicians' services furnished by the beneficiary's attending physician (who is not an employee of the hospice), or services provided by or under arrangements made by the hospice.

Duration of Hospice Care Coverage (1-2)

42 C.F.R. § 418.21 –

An individual may elect to receive hospice care during one or more of the following election periods:

- Initial 90-day period;

Duration of Hospice Care Coverage (2-2)

- Subsequent 90-day period (up to two periods); or
- Unlimited number of subsequent 60-day periods.

Certification of Terminal Illness (1 of 4)

- **42 C.F.R. § 418.22** states that the hospice must obtain written certification of terminal illness for **each** election period.
- The hospice must obtain the written certification **before** it submits a claim for payment.

Certification of Terminal Illness (2 of 4)

- For the **initial 90-day period**, the certification must be obtained from the hospice medical director, **or** the physician member of the hospice interdisciplinary group, **and** the beneficiary's attending physician *if* the beneficiary has an attending physician.
- Generally, the initial certification will contain two physician signatures.

Certification of Terminal Illness (3 of 4)

- **For subsequent periods**, the re-certification must be obtained from the hospice medical director, **or** the physician member of the hospice inter-disciplinary group.
- Generally, the recertification will contain only one physician signature.

Certification of Terminal Illness (4 of 4)

Practical Tip:

- Stamped signatures are **not** acceptable. Handwritten and electronic signatures are acceptable.

CMS, *Medicare Program Integrity Manual* (*Internet-Only Manual Publ'n 100-03*) ch. 3, § 3.3.2.4

Certification: Content Requirements (1 of 2)

42 C.F.R. § 418.22

- The certification will be based on the physician's or medical director's clinical judgment.
- The certification must *specify* that the individual's prognosis is for a life expectancy of 6 months or less if the terminal illness runs its normal course.

Certification: Content Requirements (2 of 2)

- Clinical information and other documentation that support the medical prognosis must accompany the certification.
- The physician must include a brief narrative explanation of the clinical findings that support a life expectancy of 6 months or less.

Admission to Hospice Care

42 C.F.R. § 418.25 – In reaching a decision to certify that the beneficiary is terminally ill, the hospice medical director must consider:

- Diagnosis of the terminal condition of the patient;
- Other health conditions, whether related or unrelated to the terminal condition; and
- Current clinically relevant information supporting all diagnoses.

Interdisciplinary Group

42 C.F.R. § 418.56 – The hospice must designate an **inter-disciplinary group** (in consultation with the patient's attending physician if any), which must prepare a **written plan of care** and must review and revise the plan of care as frequently as the patient's condition requires, but no less frequently than every 15 calendar days.

Interdisciplinary Group (1 of 2)

42 C.F.R. § 418.56 -

The interdisciplinary group (IDG) **must** include:

- doctor (M.D. or a D.O.);
- registered nurse;
- social worker; and
- pastor or other counselor (e.g., chaplain)

Interdisciplinary Group (2 of 2)

The IDG **may** include:

- licensed vocational nurse;
- home health aide

Covered Services (1 of 4)

42 C.F.R. § 418.202 provides a list of covered services:

- Nursing services
- Medical social services
- Physician services

Covered Services (2 of 4)

- Counseling services
- Short-term inpatient care
- Medical appliances, supplies, drugs, and biologicals

Covered Services (3 of 4)

- Home health aide services
- Physical therapy, occupational, and speech-language pathology services

Covered Services (4 of 4)

- Any other service that is specified in the patient's plan of care as reasonable and necessary for the palliation and management of the patient's terminal illness and related conditions.

Coverage Requirements (1 of 3)

42 C.F.R. § 418.200 – To be covered, hospice services must meet the following five requirements:

- The services must be reasonable and necessary for the palliation and management of the terminal illness as well as related conditions.
- The individual must elect hospice care.

Coverage Requirements (2 of 3)

42 C.F.R. § 418.200 - To be covered, hospice services must meet the following requirements:

- A plan of care must be established before hospice care is provided and the plan of care must be periodically reviewed by the attending physician, the medical director, and the IDG.

Coverage Requirements (3 of 3)

42 C.F.R. § 418.200 - To be covered, hospice services must meet the following requirements:

- The services provided must be consistent with the plan of care.
- A certification that the individual is terminally ill must be completed.

Additional Coverage Requirement (1 of 2)

42 C.F.R. § 418.22(a)(4).

- **New** Face-to-Face encounter requirement as of January 1, 2011.

Additional Coverage Requirement (2 of 2)

As of January 1, 2011, a hospice physician or hospice nurse practitioner must have a face-to-face encounter with the hospice patient no more than 30 calendar days **prior** to the start of his/her third benefit period recertification, **and** every benefit period recertification thereafter, to gather clinical findings to determine continued eligibility for hospice care.

Four Categories of Covered Hospice Care

42 C.F.R. § 418.302

- Routine Home Care
- Continuous Home Care
- Inpatient Respite Care
- General Inpatient Care

Documentation Requirements (1-2)

- Certification of Terminal Illness, 42 C.F.R. § 418.22
- Hospice Election Form, 42 C.F.R. § 418.24
- Initial and Comprehensive Assessments, 42 C.F.R. § 418.54

Documentation Requirements (2-2)

- Written Plan of Care, 42 C.F.R. § 418.56
- Physician's Order, 42 C.F.R. § 418.104

Discharge from Hospice Care (1 of 3)

42. C.F.R. § 418.26-Reasons for Discharge

A hospice may discharge a patient if:

- The patient moves out of the hospice's service area or transfers to another hospice;

Discharge from Hospice Care (2 of 3)

- The hospice determines that the patient is no longer terminally ill;
- The patient's (or others in the patient's home) behavior is disruptive, abusive, or uncooperative.

Discharge from Hospice Care (3 of 3)

- The patient decides to revoke the hospice benefit;
- The patient dies.

Limitation on Liability (1 of 3)

There are **three** situations in which hospice services may be denied that could trigger liability protection under section 1879 of the Act.

1. Not eligible because the beneficiary is **not** "terminally ill" under section 1879(g)(2) of the Act.

Limitation on Liability (2 of 3)

2. Separately billed items and/or services, such as physician services, were **not** reasonable or medically necessary under section 1862(a)(1)(A) or 1862(a)(1)(C) of the Act.

Limitation on Liability (3 of 3)

3. The level of hospice care is **not** reasonable or medically necessary under section 1862(a)(1)(A) or 1862(a)(1)(C) of the Act.

QIC's Most Common **Reasons** for Denial

(1 of 2)

No evidence of any acute clinical changes or any sustained clinical decline to support a terminal prognosis of six months or less.

QIC's Most Common **Reasons** for Denial (2 of 2)

Record did not support a ten-percent weight loss in the prior six months, severe infection, multiple decubitus ulcers, abnormal labs, or decline in functional scorings or unstable co-morbid or secondary conditions, to support a terminal prognosis of six months or less.

QIC's Most Common **Basis** for Denial

Medicare coverage guidelines of the applicable Local Coverage Determination (LCD).

- Note: An ALJ is not bound by an LCD, but will give substantial deference to an LCD if it is applicable to a particular case.

Sample LCD Language

Part I: Decline in clinical status guidelines.

Patients will be considered to have a life expectancy of six months or less if there is documented evidence of a decline in clinical status.

Sample LCD Language

Examples:

Recurrent infections like pneumonia or sepsis; 10% weight loss within the past six months; dysphagia; edema; increased pain; change in level of consciousness, decline in **KPS/PPS** score; decline in **FAST** score for dementia; Stage 3-4 pressure ulcers; increased need for **ADL** assistance.

Useful Acronyms (1 of 4)

KPS/PPS Score = Karnofsky Performance Scale; Palliative Performance Scale

- Measures one's functional impairment, in 10 percent increments.
- 0% = dead
- 10% to 40% = bed bound; no longer able to care for yourself; need assistance; disease maybe progressing rapidly

Useful Acronyms (2 of 4)

- 50% to 70% = able to care for yourself but may need some assistance
- 80% to 90% = highly functional
- 100% = normal, no complaints

Useful Acronyms (3 of 4)

FAST Score measures the progressive decline in dementia, in stages.

Stage 7 is considered late dementia, with Stage 7F being the absolute worst.

- Stage 7A= only able to speak six words or less
- Stage 7B = speech limited to one word

Useful Acronyms (4 of 4)

- Stage 7C = can no longer walk
- Stage 7D = can no longer sit up in a chair without falling over
- Stage 7E = can no longer smile
- Stage 7F = can no longer hold up head independently

CMS Manual

CMS, *Medicare Benefit Policy Manual* (*MBPM*) (*Internet-Only Manual Publ'n 100-2*) ch. 9, § 10

"Predicting of life expectancy is not always exact. The fact that a beneficiary lives longer than expected in itself is not cause to terminate benefits."

Summary (1-2)

Now that you have completed this lesson, you should now be able to:

- Identify the laws and regulations applicable to hospice care.
- Understand the terminal illness requirement.
- Describe the certification and recertification requirements.

Summary (2-2)

- Identify the services covered under the hospice benefit.
- Explain the coverage criteria for hospice care.
- Explain the documentation requirements.
- Understand how the limitation on liability provisions of section 1879 of the Act apply to hospice services.

Module 22 - Statistical Sampling

Lesson Objectives

At the completion of this lesson, you will be able to:

- Understand and define the statistical sampling process;
- Understand the scope of a statistical sampling decision; and
- Identify common issues in statistical sampling appeals.

Statistical Sampling of Claims

- Medicare contractors may use statistical sampling to project (i.e., extrapolate) overpayments to providers and suppliers when claims are voluminous and reflect a pattern of erroneous billing or overutilization and when a case-by-case review is not administratively feasible.

CMS Contractors

- Zone Program Integrity Contractors (limited to non-party status),
- Recovery Audit Contractors, or
- Medicare Administrative Contractors.

Sustained or High Level of Error

- Before using extrapolation to determine overpayment amounts to be recovered by recoupment, offset or otherwise, there must be a determination of sustained or high level of payment error, or documentation that educational intervention has failed to correct the payment error.
- However, the determination that a sustained or high level of payment error exists is not subject to administrative or judicial review.

Statistical Sampling Steps (1-2)

CMS, *Medicare Program Integrity Manual (MPIM) (Internet-Only Manual Publ'n 100-08)* ch. 8, § 8.4.1.3, provides:

- Selecting the provider or supplier;
- Selecting the period to be reviewed;
- Defining the universe, the sampling unit, and the sampling frame;

Statistical Sampling Steps (2-2)

- Designing the sampling plan and selecting the sample;
- Reviewing each of the sampling units and determining if there was an overpayment or an underpayment; and, as applicable,
- Estimating the overpayment.

Sampling Unit

- Sampling units are the elements that are selected according to the design of the survey and the chosen method of statistical sampling.
- May be individual line item(s) within a claim, an individual claim, or a cluster of claims (e.g., a beneficiary).

MPIM, supra, § 8.4.3.2.2.

Sampling Frame

- The sampling frame is the "listing" of all the possible sampling units from which the sample is selected.
- The frame may be, for example, a list of all beneficiaries receiving items or a list of specific items or services from a selected supplier.

MPIM, supra, § 8.4.3.2.3.

Sampling Design

- Simple random sampling,
- Systematic sampling,
- Stratified sampling,
- Cluster sampling,
- Or a combination of these.

MPIM, supra, §§ 8.4.4.1.1–8.4.4.1.5.

Lower Limit of 90% Confidence Interval

- Used as the amount of overpayment to be demanded from a provider.
- 90% confidence that the actual overpayment lies somewhere between the lower and upper limits of the interval.
- Accounts for any imprecision in the extrapolation in a manner that benefits the provider.

MPIM, supra, § 8.4.5.1.

Presumption of Validity

- The use of statistical sampling creates a presumption of validity as to the amount of an overpayment.
- The burden then shifts to the provider.

HCFA Ruling 86-1.

Adequate Documentation

- The contractor shall document all steps taken in the random selection process exactly as done to ensure that the necessary information is available for anyone attempting to replicate the sample.

MPIM, supra, ch. 8, § 8.4.4.2

Key Documentation (1-2)

- Specific beneficiary files;
- Notice of audit;
- Notice of overpayment;
- Lower level decisions and requests for appeal;

Key Documentation (2-2)

- Claims spreadsheet (includes names, HICNs, Claim IDs, etc.);
- Audit contractor's explanation of the audit and statistical sampling process (3-7 pages with algorithms);
- Random number file; and
- Universe of claims file.

Validity of Sampling Methodology (1-2)

Determine the validity of the statistical sampling process.

- Regardless of the method of sample selection used, the contractor shall follow a procedure that results in a probability sample.
- If a probability sample design is properly executed, then its results are always valid.

MPIM, supra, § 8.4.2.

Validity of Sampling Methodology (2-2)

If the appellant does not state the reasons the appellant disagrees with how the statistical sample and/or extrapolation was conducted in the request for hearing, issues related to how the statistical sample and/or extrapolation were conducted shall not be considered or decided by the adjudicator.

42 C.F.R. § 1032(d)(1).

Review the Sample Claims

When the appellant asserts a disagreement with how a statistical sample and/or extrapolation was conducted in the request for hearing, the adjudicator must base his or her decision on a review of the entire statistical sample in order to decide the issue.

42 C.F.R. § 405.1032(d)(2).

Liability/Overpayment

- For claims denied on the basis of § 1862(a)(1) or 1862(a)(9) of the Act, analyze liability under § 1879 of the Act.
- Then proceed to analysis of waiver of overpayment under § 1870 of the Act.

Common Issues (1-7)

Challenges to the validity of reopening

- 42 C.F.R. §§ 405.980 and 405.986.

The decision to reopen is not appealable.

- 42 C.F.R. § 405.980(a)(5).
- 42 C.F.R. § 405.926(l).

Common Issues (2-7)

Challenge to Validity of Reopening Claims

- *Chevron, U.S.A., Inc. v. NRDC, Inc.*, 467 U.S. 837 (1984)
- 42 C.F.R. §§ 405.980(a)(5) and 405.926(l)
- 70 Fed. Reg. 11420, 11453 (Mar. 8, 2005)

Common Issues (3-7)

Thomas Jefferson University v. Shalala, 512 U.S. 504 (1994)

- An agency's interpretation of its own regulations must be given "substantial deference."
- A court "must defer to the Secretary's interpretation [of a regulation] unless an alternative reading is compelled by the regulation's plain language or -

Common Issues (4-7)

- by other indications of the Secretary's intent at the time of the regulation's promulgation." *Thomas Jefferson*, 512 U.S. at 512.

Common Issues (5-7)

Precision Challenge to Sampling Process.

- The *MPIM* does not prescribe a particular sample size or precision. Similarly, the *MPIM* does not prescribe any particular sampling design, but notes that any sample design that results in a probability sample, -

Common Issues (6-7)

- including simple random sampling, systematic sampling, stratified sampling, or cluster sampling is acceptable. *MPIM*, ch. 8, §§ 8.4.2 and 8.4.4.1.

Common Issues (7-7)

Precision Challenge to Sampling Process

- The *MPIM* explicitly provides it is not improper and is, in fact, a requirement for contractors to consider "real-world economic constraints," such as "the level of available resources," when choosing a sampling methodology. *See MPIM*, supra, ch. 8, §§ 8.4.2 and 8.4.4.3.

Use of Experts (1-2)

Experts may be used where there is an issue that the adjudicator is unable to resolve.

- For example: whether a person's condition warranted a type of care; whether a treatment was the standard of care for a disorder; or where a treatment or test has no LCD, is new, and the provider has supported the use of the technique with medical evidence, journals, etc.

Use of Experts (2-2)

Experts may be used where there is an issue that the adjudicator is unable to resolve.

- For statistical sampling, an expert may analyze the contractor's sampling methodology for errors, comparing it to CMS requirements in chapter 8 of the *MPIM*, CMS Transmittal B-03-022, and generally accepted statistical principles.

Ambulance Cases

- The use of statistical sampling in ambulance cases, which are denied under § 1861(s)(7) of the Act, raises significant procedural and due process concerns.

- Beneficiaries in the sample and universe are entitled to notice of hearing and notice of ALJ decision because of their party status, which eliminates the administrative efficiency typically created by statistical sampling.

Legal Authority - Major Authorities

- Act § 1893
- CMS, *MPIM, supra,* ch. 8
- HCFA Ruling 86-1
- CMS Program Memorandum, B-03-022 (March 21, 2003)

Summary

Now that you have completed this lesson, you should be able to:

- Understand and define the statistical sampling process;
- Understand the scope of a statistical sampling decision; and
- Identify common issues in statistical sampling appeals

Module 23 - Entitlement Appeals

Lesson Objectives

At the completion of this lesson, you will:

- Understand How Part B Entitlement Appeals Typically Arise;
- Be Able To Resolve A Typical Part B Entitlement Appeal; and
- Be Familiar With Applicable Law and Policy

As A Practical Matter, *think*

ENTITLEMENT = ENROLLMENT

How Part B Entitlement Appeals Arise

- SSA makes initial determinations and handles reconsiderations
- HHS is responsible for OMHA and Council review

General Background: Part B Eligibility

Individuals entitled to premium-free Part A

- Aged
- Disabled
- ESRD

Who is Eligible?

Individuals 65 and older

- US citizens who reside in the US
- Legal Permanent Residents (LPRs) in the US five years prior to enrollment

What are the Enrollment Periods?

- Initial Enrollment Period
- General Enrollment Period
- Special Enrollment Period

Initial Enrollment Period

- Begins: 3 months before Part A eligibility
- Ends: 7 months later

General Enrollment Period

- Runs each calendar year from January 1st through March 31st
- Effective date of enrollment is July 1st
- 10% premium surcharge (for each 12 month period)

Special Enrollment Period

- If enrolled during SEP, premium surcharge not applicable
- If not enrolled during SEP, must wait for GEP

Special Enrollment Period

- The Individual's non-enrollment was unintentional, inadvertent or erroneous and is result of the error, misrepresentation, or inaction of an office, employee or agent of the Federal Government; Act §1837(h)

- The individual did not enroll at the time they became initially eligible for Part B because the individual was enrolled in an employer's group health plan due to the individual, or their spouse's, current employment status; Act §1837(i)

- The individual did not enroll at the time they became initially eligible for Part B because the individual was serving as a volunteer outside of the United States through a qualified program and satisfied other requirements; Act §1837(k)

Special Enrollment Period

- Any time while covered under employer's group health plan (GHP) based on *current employment (or spouse's)*,

  or

- During the 8 months after it ends

What is the "Penalty" for Late Enrollment?

- Individuals enrolling during a GEP are assessed a 10% increase in premium for each full 12-month period they could have been enrolled, but were not

Calculating the Premium Surcharge

- 10% premium surcharge for every full 12-month period not enrolled in Part B and no GHP coverage

- Must pay surcharge as long as enrolled

Calculating the Months

- Start first month after IEP
- End last month of the enrollment period

Surcharge Example

- IEP ends 5/2010
- Individual enrolls 3/2014 GEP
- Months from 6/2010 to 3/2014 = 46
- Therefore, 30% premium surcharge

Typical Entitlement Appeal

- Opted out or declined to enroll when first eligible
- Recently enrolled because no longer covered under a group health plan

Typical Entitlement Appeal – Cont'd

- SSA assessed a large surcharge,
  e.g. 150%, to the standard premium

- Contends she was advised that she could apply late without penalty

What Relief is Available?

- Where an individual's enrollment or nonenrollment is unintentional, inadvertent, or erroneous and the result of error, misrepresentation, or inaction of an agent of the Federal Government, the Secretary may take such action necessary to correct or eliminate the effects of such error, misrepresentation, or inaction.

  Social Security Act § 1837(h)

What Relief is Available?

SSA or CMS may:

- Designate a special initial or general enrollment period
- Designate an entitlement period based on that enrollment period

What Relief is Available?

- Adjust premiums
- Take any other action necessary to correct or eliminate the effects of the error, misrepresentation, or inaction.

42 C.F.R. § 407.32

Premium Surcharge Relief

Relief available if:

- SSA/CMS/Medicare contractor is at fault
- SSA/CMS/Medicare documents the fault
- The enrollee acted reasonably

CMS policy

CMS requires 'more-than-clean hands':

- The individual took reasonable, appropriate, and timely measures to assert his or her rights;
- Due to administrative fault, his or her rights have been or are likely to be impaired unless relief is given.

SSA policy

SSA imposes essentially the same requirement, but also requires:

- That the error, misstatement, or inaction be attributable directly or indirectly to someone authorized to act for the Federal Government in Medicare matters (such as an employee of SSA, CMS, or a CMS contractor)

SSA policy – Cont'd

- That such error, misrepresentation, or inaction is documented

SSA, *POMS, supra,* ch. HI 008,
§ 00805.170.D

Applicable Authorities

- Social Security Act
- Code of Federal Regulations
- CMS policy
- SSA policy
- Council actions/decisions

Resources

Web Resources:

- Enrolling in Medicare Part A & Part B:

https://www.medicare.gov/Pubs/pdf/11036-Enrolling-Medicare-Part-A-Part-B.pdf

- General information on enrollment in Medicare:

http://medicare.gov/sign-up-change-plans/index.html

Resources

Web Resources

- Medicare premium amounts: http://medicare.gov/your-medicare-costs/index.html

- Medicare & You Handbook: http://medicare.gov/medicare-and-you/medicare-and-you.html

Hypothetical #1

SSA found the enrollee disabled due to a mental impairment. When completing the enrollee's Title II paperwork, the local SSA representative advised the enrollee's mother the enrollee would become eligible for Medicare Part B in March 2002. Based on the father's earnings report, SSA also advised the enrollee would not have to apply for Medicare Part B in March 2002 because the enrollee was covered under his father's employer's group health plan.

Hypothetical #1 - Cont'd

- Shortly thereafter, the father retired. In March 2002, the enrollee purposely did not enroll in Medicare Part B. When his father passed away in August 2005, however, the enrollee's mother promptly contacted SSA and enrolled her son in Medicare Part B. SSA assessed a 30% Medicare Part B premium surcharge. On reconsideration, SSA upheld the surcharge and the enrollee appealed to OMHA. Pending that appeal, the local SSA office submitted a Report of Contact that confirmed the above.

Hypothetical #1 - Cont'd

- Issue 1: whether SSA correctly assessed a premium surcharge.

- Issue 2: whether the enrollee is entitled to relief from the premium surcharge.

Suggested Answer

Answer to Issue 1: SSA correctly assessed a 30% premium surcharge. So long as the enrollee was covered under a group health plan *on account of his father's* ***current*** *employment,* the enrollee was "protected" by a special enrollment period. 42 C.F.R. § 407.20. However, his "protection" ended when his father retired. Because three full 12-month periods had passed since the enrollee could have enrolled, SSA correctly assessed the 30% premium surcharge. *See* 42 C.F.R § 408.22.

Suggested Answer - Cont'd

- Answer to Issue 2: The enrollee is entitled to relief. Relief is warranted because an SSA representative provided incorrect material information upon which the enrollee reasonably relied to his detriment, SSA documented the error, and the enrollee acted promptly in seeking enrollment. *See* CMS, *General Information, Eligibility and Entitlement Manual (GIEEM) (Internet-only Manual, Publ'n 100-01)* ch. 2, § 40.8 (Sep. 16, 2010); and SSA, *POMS* HI 008, § 00805.170.D (Mar. 12, 1999).

Hypothetical #2

The enrollee was born May 19, 1938. The enrollee was convicted of felony DUI vehicular manslaughter and incarcerated from May 1998 through December 2006. The enrollee was 60 years old when he entered prison and turned 65 in prison. Throughout his incarceration, the enrollee was a member of the general prison population, had access to the prison library and U.S. mail system, and the state provided for all of the enrollee's medical needs.

Hypothetical #2 - Cont'd

Within 3 days of release, the enrollee applied for Medicare benefits but was assessed a 30% premium surcharge due to late enrollment. On appeal, the enrollee argued he should not be assessed the surcharge because he could not enroll in Medicare while incarcerated, he never received notice he had to enroll when he turned 65, and he was protected by a special enrollment period because the state provided mandatory health coverage for him during his incarceration and he promptly enrolled when he was released.

Hypothetical #2 - Cont'd

Issue: whether SSA correctly assessed a premium surcharge

Suggested Answer

SSA correctly imposed a 30% premium surcharge. The enrollee became eligible for Part B when he turned 65, did not apply until December 2006, and is deemed to have applied during the 2007 GEP. As a member of the general prison population, the enrollee had library and mail access. Imprisonment did not render the enrollee ineligible or incapable of applying for Medicare Part B. *See* SSA, POMS HI § 00805.005.D.6 (incarcerated felons whose Social Security benefits are suspended nonetheless retain Medicare Part B eligibility).

Suggested Answer - Cont'd

See also SSA, POMS HI § 00805.100 (no enrollment period can be extended because the individual is mentally incompetent during part or all of the period, or because he or she may have been physically incapacitated). Moreover, as the Medicare Appeals Council has noted, neither SSA nor CMS is required to provide notice to individuals who are not subject to Medicare Part B provisions for deemed or automatic enrollment. *In re J.B.K.,* at n.3, MAC (Nov. 18, 2009). "It is generally the beneficiary's responsibility to initiate

Suggested Answer - Cont'd

contact with SSA, based on information in the public domain and government public education and outreach efforts." *Id.* at 4. Finally, there is no evidence the state provided coverage pursuant to a group health plan, and the enrollee had no employment relationship with the state. His relationship arose by force and operation of law due to a criminal conviction, and not by mutual consent. *Cf.* SSA, POMS RS § 01901.560.B.3 (no employment relationship exists between an inmate and state prison for Title II purposes).

Hypothetical #3

The enrollee, a practicing trial lawyer, was born May 15, 1944. Anticipating his 65th birthday, the enrollee applied for Part A and enrolled effective May 2009; however, the enrollee explicitly declined Part B enrollment. The enrollee testified he changed his mind, advised SSA by phone March 24, 2009 he had decided to enroll, and was told SSA would send a Part B application form. The enrollee further testified he called SSA again April 30, 2009 and advised SSA he had not received his application form; the enrollee then

Hypothetical #3 - Cont'd

was informed his previous call was noted in SSA's computer, SSA would send the application form that day, and SSA would make a computer entry that the enrollee should not be penalized for late enrollment. On May 1, 2009, SSA mailed a Part B application form which the enrollee immediately signed and returned. On May 11, 2009, the enrollee suffered a heart attack. The enrollee had no medical insurance other than Medicare.

Hypothetical #3 - Cont'd

The enrollee was covered under Part A effective May 2009 but not covered under Part B until June 2009. SSA's records reflect the enrollee's address was updated in March 2009; however, there was no Report of Contact or other record that the enrollee communicated any interest in applying for Medicare Part B (or had requested a Medicare Part B application) at any time prior to his April 30, 2009 "follow-up" call.

Hypothetical #3 - Cont'd

Issue: whether the enrollee is entitled to adjust his Medicare Part B enrollment date.

Suggested Answer

The enrollee is not entitled to relief. The record does not contain a Report of Contact or other document evidencing misrepresentation, inaction, or error by SSA. While the enrollee might have contacted SSA in March, the credibility of the testimony is undermined by the lack of supporting documentation. The only corroborated testimony is the enrollee called SSA April 30, 2009 and SSA promptly mailed the Part B application form the following day.

Suggested Answer - Cont'd

Even if the enrollee had requested an application form March 24, the Enrollee offered no explanation (plausible or not) as to why he did not act sooner before contacting SSA concerning the "missing" application form. The enrollee was a practicing trial attorney with no physical or mental deficits. Merely requesting an application form did not prevent him from following up earlier than he did with a telephone call, applying online, or even applying in-person. *See* CMS, *GIEEM (Internet-only Manual Publ'n 100-01)* ch. 2, § 40.8 (Sept. 16, 2010).

Summary

You should now:

- Understand How Part B Entitlement Appeals Typically Arise;
- Be Able To Resolve A Typical Part B Entitlement Appeal; and
- Be Familiar With Applicable Law and Policy

Module 24
Income-Related Monthly Adjustment Amount (IRMAA)

Glossary

- IRMAA: Income-Related Monthly Adjustment Amount
- LCE: Life Changing Event
- MAGI: Modified Adjusted Gross Income
- PY: Premium Year
- SMI: Supplementary Medical Insurance or Part B
- SSA: Social Security Administration

What is IRMAA? (1-6)

IRMAA affects premiums for Medicare Part B, which covers doctor's visits and other outpatient services, as a result of the Medicare Modernization Act of 2003.

20 C.F.R. § 418.1001

What is IRMAA? (2-6)

- IRMAA also affects premiums for Medicare Part D, which covers prescription drugs, as a result of the Affordable Care Act of 2010.

20 C.F.R. § 418.1001.

See, generally, 20 C.F.R. §§ 418.1001-1355 (Part B), 418.2001-2355 (Part D)

What is IRMAA? (3-6)

- IRMAA is the amount an individual pays in addition to the standard Medicare Part B or Part D monthly premium, when an individual's modified adjusted gross income (MAGI) exceeds the annual threshold.

20 C.F.R. §§ 418.1005 (Part B), 418.2005 (Part D)

What is IRMAA? (4-6)

- The amount of an IRMAA is determined according to the individual's MAGI and federal tax filing status.

20 C.F.R. §§ 418.1005 (Part B), 418.2005 (Part D)

What is IRMAA? (5-6)

- The amount of an IRMAA is determined according to the individual's MAGI and federal tax filing status.

20 C.F.R. §§ 418.1005 (Part B), 418.2005 (Part D)

What is IRMAA? (6-6)

- Without IRMAA, individuals pay approximately 25% of the actual costs of the Medicare Part B and Part D programs while the federal government covers remaining program costs.

20 C.F.R. §§ 418.1005 (Part B), 418.2005 (Part D)

MAGI (1-2)

- Modified Adjusted Gross Income (MAGI) equals:
  - IRS Form 1040, Line 37 [Adjusted Gross Income]

  PLUS
  - IRS Form 1040, Line 8B [Tax Exempt Income]

20 C.F.R. §§ 418.1010(b)(6) and 418.1120(a) (Part B)

20 C.F.R. §§ 418.2010(b)(5) and 418.2120(a) (Part D)

MAGI (2-2)

Why is MAGI important?

- SSA uses filing status and MAGI to determine whether an IRMAA will be assessed and, if so, the amount.

See 20 C.F.R. §§ 418.1125 (Part B), 418.2125 (Part D)

Income Thresholds

IRS Tax Filing Status	2011 – 2019 MAGI
Married, filing jointly	$170,000
All Others	$85,000

Based on the corresponding IRS tax filing status indicated above, beneficiaries who exceed the indicated MAGI thresholds are subject to IRMAA.

20 C.F.R. §§ 418.1105 (Part B), 418.2105 (Part D)

IRMAA Determinations (1-4)

- SSA makes all IRMAA initial determinations.

20 C.F.R. §§ 418.1301 (Part B), 418.2301 (Part D)

IRMAA Determinations (2-4)

- SSA calculates IRMAA using tax information received from the IRS. Ordinarily, this is an individual's tax information from two years prior to the premium year (PY-2).

20 C.F.R. §§ 418.1135(a) (Part B), 418.2135(a) (Part D)

IRMAA Determinations (3-4)

- If PY-2 tax information is not available, SSA will use the PY-3 tax information temporarily until the PY-2 information is available.

20 C.F.R. §§ 418.1135(b) (Part B), 418.2135(b) (Part D)

IRMAA Determinations (4-4)

- This is the standard IRMAA process for every premium year.

20 C.F.R. §§ 418.1135 (Part B), § 418.2135 (Part D)

If your filing status and yearly income in 2018 was

If you filed as:	With MAGI of:	Part B IRMAA is:	Prescription Drug coverage IRMAA for 2017 is:
Single, Head of household or Qualifying Widow(er)	$85,000.01 - $107, 000.00 $107,000.01- $133,500.00 $133,500.01-$160,000.00 More than $160,000.00	$53.50 $133.90 $214.30 $294.60	$13.00 $33.60 $54.20 $74.80
Married, filing jointly	$170,000.01-$214, 000.00 $214,000.01-$267,000.00 $267,000.01-$320,000.00 More than $320,000.00	$53.50 $133.90 $214.30 $294.60	$13.00 $33.60 $54.20 $74.80
Married, filing separately	More than $85,000.00	$294.60	$74.80

IRMAA Appeals (1-7)

- Following an initial determination, a beneficiary may request reconsideration.

- SSA handles all IRMAA requests for reconsideration.

20 C.F.R. §§ 418.1325 (Part B) and 418.2325 (Part D).

IRMAA Appeals (2-7)

- Reconsideration issues usually concern whether SSA should calculate MAGI using more recent tax information.

See 20 C.F.R. §§ 418.1201 and 418.2201.

IRMAA Appeals (3-7)

- IRMAA appeals usually concern whether an individual is entitled to relief based on a major Life Changing Event.
- Individuals appeal unfavorable IRMAA reconsidered determinations to OMHA.

IRMAA Appeals (4-7)

- 42 C.F.R. Part 405, Subpart I governs the Part B IRMAA appeals process.
- 20 C.F.R. § 418.1350 provides in relevant part: "You may request a hearing before an OMHA administrative law judge consistent with HHS' regulations at 42 C.F.R. Part 405."

IRMAA Appeals (5-7)

- 42 C.F.R. Part 423 governs the Part D IRMAA appeals process.
- 20 C.F.R. § 418.2350 provides in relevant part: "You may request a hearing before an OMHA administrative law judge consistent with HHS' regulations at 42 C.F.R. Part 423."

IRMAA Appeals (6-7)

- The issue before an OMHA ALJ usually concerns whether the individual's IRMAA may be reduced or eliminated by using MAGI for a more recent year when the individual claims a Life-Changing Event.

20 C.F.R. §§ 418.1201 (Part B), 418.2201 (Part D)

IRMAA Appeals (7-7)

- By regulation, an individual's IRMAA will be reduced or eliminated if:
  - The individual experienced a major life changing event as defined by regulation;
  - The major life-changing event resulted in a significant reduction in MAGI in a more recent tax year;
  - The individual requests the use of a more recent tax year's MAGI; and
  - The individual provides acceptable evidence.

- 20 C.F.R. §§ 418.1201 (Part B), 418.2201 (Part D)

7 Major Life-Changing Events: The Checklist (1-2)

1. Marriage;
2. Death of a spouse;
3. Marriage ends through divorce or annulment;
4. You or your spouse stop working or reduce the hours you work;

7 Major Life-Changing Events: The Checklist (2-2)

5. Loss of income-producing property;
6. Cessation, termination or reorganization of employer's pension plan; or,
7. Settlement received as a result of employer's closure, bankruptcy, or reorganization.

20 C.F.R. §§ 418.1205 (Part B), 20 C.F.R. § 418.2205 (Part D)

The most common case / LCE: Loss Of Income-Producing Property

You or your spouse experiences a loss of income producing property, provided the loss is not at the direction of you or your spouse (e.g., due to the sale or transfer of the property) and is not a result of the ordinary risk of investment.

20 C.F.R. § 418.1205(e)

Timing of LCE (1-3)

Unlike the PY-3 or PY-2 IRMAA calculation rule, the occurrence of an LCE is not limited to a particular year or time period. The only requirement is that the LCE had to happen prior to the request.

Timing of LCE (2-3)

Example:

- Joe Smith received his IRMAA notice in November 2016 for PY 2017; the IRMAA was calculated using his 2015 MAGI;
- Mr. Smith had a qualifying LCE occur in December 2016 that would result in a significant reduction in his MAGI for tax year 2016;

Timing of LCE (3-3)

- Mr. Smith requests SSA use his 2016 MAGI based on his qualifying LCE;
- Mr. Smith qualifies for use of his 2016 MAGI;
- SSA will accept an estimate of Mr. Smith's 2016 MAGI if actual figures are not yet available.

A Significant Reduction

- With respect to Part B, 20 C.F.R. § 418.1215 provides, in part:
  - "For purposes of this subpart, we will consider a reduction in your income to be significant if your [MAGI] decreases; and
  a) The decrease reduces the percentage of the [IRMAA] you must pay … ; or
  b) The decrease reduces your [MAGI] to an amount below the threshold … and eliminates any [IRMAA] you must pay."

(applicable to Part D through 42 C.F.R. § 418.2215)

Evidence Requirement

- With respect to Part B, 20 C.F.R. § 418.1215 provides, in part:
  - "When you request that we use a more recent tax year to determine your [IRMAA], we will ask for evidence of the major [LCE] and how the event significantly reduced your [MAGI] as described in §§ 418.1255 and 418.1265. Unless we have information in our records that raises a doubt about the evidence, additional evidence documenting the major [LCE] will not be needed."

(applicable to Part D through 42 C.F.R. § 418.2250)

Kinds of LCE Evidence (1-2)

20 C.F.R. §§ 418.1255 (Part B) and 418.2255 (Part D)

- Provide the type of evidence and/or references to the type of evidence SSA will accept as evidence of a major LCE.

Kinds of LCE Evidence (2-2)

20 C.F.R. §§ 418.1260 (Part B) and 418.2260 (Part D)

- Provide the type of evidence and/or references to the type of evidence SSA will not accept as evidence of a major LCE.

Kinds of Significant Evidence

20 C.F.R. §§ 418.1265 (Part B) and 418.2265 (Part D)

- Provide the type of evidence and/or references to the type of evidence SSA will accept as evidence of a significant reduction in MAGI.

Expenses Not Qualifying LCEs

20 C.F.R. §§ 418.1210 (Part B) and 418.2210 (Part D)

Certain types of events are not considered major [LCEs] for the purposes of this subpart, such as:

a) "Events that affect your expenses, but not your income; or

a) Events that result in the loss of dividend income because of the ordinary risk of investment."

Sample Cases (1-11)

Fact Pattern – Case A

Husband and wife, Part B beneficiaries, sold their stocks in order to move into a nursing home. The beneficiaries' 2015 MAGI was $317,417.00. Based on their MAGI, each beneficiary was assessed an IRMAA of $49.40 for 2017. The beneficiaries did not dispute the calculation of their MAGI.

Sample Cases (2-11)

Fact Pattern – Case A

The ALJ found, based on their age and failing health, that the beneficiaries had been forced to sell their stocks "due to circumstance beyond the[ir] control...,which qualifies as a life changing event." The ALJ concluded the life-changing event was the "forced selling of income producing property, in the instant case, stock."

Sample Cases (3-11)

Fact Pattern – Case A

SSA protested, stating it "will not consider events other than those described in § 418.1205 to be major life-changing events. Certain types of events are not considered major life-changing events for the purposes of this subpart, such as: … (b) Events that result in the loss of dividend income." 20 C.F.R. § 418.1210(b).

Sample Cases (4-11)

Fact Pattern – Case A

SSA further asserted that its regulations treat a loss from the sale of stock, like the ones at issue, in the same manner as a loss of dividend income. 71 Fed. Reg. 62923, 62929 (2006) (noting in response to public comments on this issue that "decreases in dividend income and loss of income from financial securities are not 'events' but rather fluctuations in the financial markets and should not be considered as part of the list of events with a potentially permanent effect on income" that qualify as major life-changing events).

Sample Cases (5-11)

Fact Pattern – Case A

Question: What did the Council rule in this scenario?

Sample Cases (6-11)

Fact Pattern – Case A

Answer: The Council found that the "beneficiaries' circumstances did not qualify as a life-changing event under the IRMAA regulations." The Council also determined that the ALJ erred in ruling that the beneficiaries' sale of stock satisfied the requirements of 20 C.F.R. § 418.1201(a).

Sample Cases (7-11)

Fact Pattern – Case B

The Part B beneficiary's 2015 MAGI was $203,721.00. Based on the beneficiary's MAGI, SSA assessed the beneficiary an IRMAA of $67.90 for 2017. In December 2016, the beneficiary notified SSA he had a life-changing event because he stopped working in June 2006. SSA used the beneficiary's 2016 earnings to reduce his IRMAA from $67.90 to $30.90. In January 2017, the beneficiary requested reconsideration and asked that SSA use his 2017 estimated earnings to recalculate his 2017 IRMAA. SSA did not take into account the stop work life-changing event.

Sample Cases (8-11)

Fact Pattern – Case B

On March 15, 2017, the beneficiary requested an ALJ hearing. Among other things, the ALJ found the beneficiary's 2017 tax year income was "speculative" and would be "uncertain until such time as his TY2007 tax returns are filed."

Sample Cases (9-11)

Fact Pattern – Case B

The appellant appealed, arguing "the ALJ's decision in this case is inconsistent with the statute and regulations in that [the beneficiary's] MAGI was computed using his 2016 tax return. Since [the beneficiary] had a [life-changing event] in 2016 (work stoppage), he should have been allowed to use his estimated earnings for the year 2017 to compute his IRMAA for premium year 2017. --

Sample Cases (10-11)

Since SSA's regulations allow for use of estimated earnings when the tax return has not been filed, [the beneficiary] should have been allowed to have a new initial determination based on his estimated earnings for the tax year 2017. The ALJ's decision is therefore contrary to SSA regulations."

Sample Cases (11-11)

Fact Pattern – Case B

Question: What did the Council rule in this scenario?

Answer: On November 28, 2017, the Council found the beneficiary had a qualifying life-changing event in 2016. The Council agreed with the appellant and concluded "the beneficiary may, under the applicable SSA regulations, request that his estimated 2017 MAGI be used to calculate his IRMAA for 2017."

Module 25: Medicare Secondary Payer

Objectives (1-2)

At the completion of this lesson, you will be able to:

- Understand how the Medicare Secondary Payer (MSP) program works;
- Identify the ways MSP claims can be reduced;

Objectives (2 of 2)

- Determine settlement recoveries in wrongful death and Workers' Compensation awards; and
- Identify the procedural differences under the Strengthening Medicare and Repaying Taxpayers Act of 2012 (SMART) Act.

MSP Background

- Designed to reduce the amount of payments made by the Medicare program by requiring other insurers of health care for beneficiaries to pay primary to Medicare.

Applicable Laws (1-2)

- Social Security Act (Act) § 1862(b)
- 42 C.F.R. §§ 411.50-54
- 42 C.F.R. §§ 411.40-47
- 42 C.F.R. §§ 411.100-130

Applicable Laws (2-2)

- 42 C.F.R. § 405.355
- 42 C.F.R. § 405.924
- 42 C.F.R. § 405.926
- 20 C.F.R. § 404.509
- CMS, Medicare Secondary Payer Manual (MSPM) (Internet-Only Manual Publ'n 100-5)

MSP - Application

MSP is triggered by:

OTHER INSURANCE COVERAGE

- Liability Insurance – 42 C.F.R. § 411.50
- Automobile
- General casualty
- Workers' Compensation

Liability Insurance (1-2)

Who: Injured Medicare Beneficiary

What: Third-Party Liability insurance

Liability Insurance (2-2)

When: Medicare will pay for medical services only when the third-party insurance payment will not be **"prompt."**

More About Liability Insurance (1-2)

"Prompt"

Within 120 days

42 C.F.R. § 411.50(b)

More About Liability Insurance (2-2)

- Medicare's payments are "**CONDITIONAL**"
- Medicare expects repayment when the private insurance payment "**has been made, or can reasonably be expected to be made.**"

CMS Collection Powers (1-2)

- Subrogation rights
- Right to bring independent actions against any entity that has received payment from a primary plan

CMS Collection Powers (2-2)

- Recover from **any** entity "required" or responsible to repay
- Recover from **any** entity receiving the other insurance proceeds

Act § 1862(b)(2)(B)(ii) – (iv)

MSP Collection Process (1-4)

MSP Timeline

- Beneficiary, or representative, provides notice to Medicare within 60 days of receiving a settlement. 42 C.F.R. § 411.24(h)
- CMS Information Gathering (MSPRC)

MSP Collection Process (2-4)

- CMS sends collection letter
- Amount is determined by a Coordination of Benefits Contractor based on claims for Medicare services

MSP Collection Process (3-4)

- Required Letter Contents
  - Repayment process
  - Waiver of repayment procedures, and
  - Applicable appeals process

MSP Collection Process (4-4)

- Beneficiary/Representative responds by:
  - Paying amount claimed
  - Seeking a reduction
  - Seeking a waiver

MSP Recovery Amount

- CMS may recover an amount equal to the Medicare payment for injuries covered by the liability insurance, up to the full amount payable under the insurance.

42 C.F.R. § 411.24(c)

MSP Recovery Limitations (1-2)

No MSP recovery for services covered by Medicare after the date of settlement

- Unless settlement includes future medical services.

MSP Recovery Limitations (2-2)

Medicare must reduce its MSP recovery for **Procurement Costs**

- Proportionate share of attorneys' fees/costs

42 C.F.R. § 411.37(a)(1) and (d)

Appeals Issues

Reduction of MSP Claim Sought

- Unrelated charges included in MSP Claim. MSPM, ch. 7, § 50.4.4.
- Compromise of Small Settlement; CMS Regional Offices ONLY!!
  - Act § 1862(b)(2)(B)(v)
  - 42 C.F.R. § 411.28(b)