POLICY AND PROCEDURE

DEPARTMENT: Operations - Payment Integrity	**DOCUMENT NAME:** Payment Integrity Vendor Post Payment Audits (Home Health, SNF and DME)
PAGE: 1 of 6	**REPLACES DOCUMENT:**
APPROVED DATE: 01/19/21	**RETIRED:**
EFFECTIVE DATE: 3/1/15	**REVIEWED/REVISED: 3/17, 4/18, 4/19, 01/21, 1/22, 1/23, 12/23, 2/24, 2/25**
PRODUCT TYPE: All	**REFERENCE NUMBER: CC.PI.11**

SCOPE:
This policy applies to employees of Centene Corporation and its subsidiaries (collectively, the "Corporation").

PURPOSE:
The purpose of this policy is to define the Payment Integrity audit procedure for Home Health Services, Skilled Nursing Facility Services, and Durable Medical Equipment (DME) post payment claim reviews conducted on behalf of Centene by an external vendor.

POLICY:
It is the policy of the Corporation to comply with provisions set forth in the contract with the state in which they operate, and meet or exceed all State or Federal requirements and timeframes. In order to comply with these provisions, Centene has the right to audit medical claims and medical records post payment to ensure claims were billed correctly.

PROCEDURE:
1. Centene sends paid claims data weekly to an external vendor for all Health Plans. The external vendor conducts targeted data analysis that considers the diagnosis and procedures billed, length of stay, and other elements in the claim data that identify potential billing errors. The external vendor will decide using algorithms and business experience which claims are more likely billed incorrectly. Based on this information, the external vendor will send a selection list of claims they would like to audit for each Health Plan implemented on the audit process.

2. The selection list is reviewed by a member of the Payment Integrity team to ensure overlap and/or duplication of recovery efforts does not occur on any claim. Any claim that has been previously identified by Payment Integrity or other dept. for recoupment is excluded from the selection list. The selection list is then reviewed by the Health Plan(s) to decide if any claims/providers should be excluded from the audit selection list. The approved list is then forwarded to the external vendor.

3. The external vendor will request medical records for the claims to be audited.

4. Once medical records have been received, the external vendor conducts the audit which will result in a 'no change' or 'change' finding. Response letters are then sent to providers with the 'no change' or 'change' findings.

5. Claims analysts adjust claims payment according to the audit findings after the appropriate provider recovery notification process is followed.

6. All levels of appeals are handled by the external vendor, when approved to do so, and with consult from the Health Plan when necessary.

7. For the external vendor audits in the Medicaid and Marketplace LOBs, Plan State Guidelines are used as audit criteria to determine if the claim was billed and paid correctly.

8. For the external vendor audits in the Medicare LOBs, the following audit criteria is used in order to determine if the claim was billed and paid correctly, according to Federal CMS guidelines:

9. If a provider does not comply with a medical record request after three letters and at least one phone outreach, then a Technical Denial, or administrative denial, will occur. Thirty days from the third and final letter, when contractually able, the full claim payment will be recovered (amount will be offset against future payments) due to noncompliance. Provider requests to reopen these denials will be reviewed if and only if the request occurs within sixty days of the technical denial letter sent date. Documents submitted after the allotted timeframe has passed will not be accepted for review.

Audit Criteria-Home Health

- ❑ The care provided requires the skill of a licensed professional in order to bill.
- ❑ The agency should provide documentation to support each billed visit for all disciplines.

- The agency should provide a completed Plan of Care for the requested episode. The Plan of Care should be established and approved by a Physician.
- Each billed visit should have an order for that visit.
- If any services are provided based on a physician's oral orders, the orders must be put in writing, and signed by Physician.
- Each patient must qualify for Home Health Services. They do not have to be bedridden to be considered confined to the home. However, the condition of these patients should be such that there exists a normal inability to leave home and, consequently, leaving home would require a considerable and taxing effort.
- The number of therapy visits projected on the OASIS assessment M2200 at the start of the episode should match the billed visits Low Utilization Payment Adjustments (LUPAs)
- If an HHA provides four visits or less in an episode, they will be paid a standardized per visit payment instead of an episode payment for a 30-day period.
- The agency should provide an OASIS that support the HIPPS Code billed for the requested episode. The agency should provide a completed OASIS Assessment. The total case-mix adjusted episode payment (HIPPS code) is based on the answers of (up to) 38 OASIS assessment MO/M items
- The agency is to report whether an episode is “early” or “later” using OASIS item M0110. This OASIS information is then used to determine the HIPPS code used for billing.
- As identified in (M0080) Discipline of Person Completing Assessment, the comprehensive assessment and OASIS data collection should be conducted by a registered nurse (RN) or any of the therapies (PT, SLP/ST, OT).
- The OASIS should be signed and dated by assessing clinicians for validation. Mistakes or errors should be documented appropriately by a single line through the incorrect information.
- When is a recertification (follow-up) assessment due for a home health patient and patient remains on service into a subsequent episode this requires a follow-up comprehensive assessment

(including OASIS items) during the last 5 days of each 30-day period (days 56-60, counting from the start of care date) until discharged.

- ❑ Audits utilize, where applicable, CMS PDGM coverage and reimbursement methodology for dates of service effective 1/1/2020.

Audit Criteria-Skilled Nursing Services:

- ❑ Clinical documentation to support correct PDPM scoring.
  - Correct coding
  - Appropriate admission (CMS only)
  - Patient Driven Payment Model (PDPM)
  - RUG coding/Improper Case Mix
  - Per Diem validation
  - Length of stay
  - Delivery of services
  - Therapy
- ❑ Clinical documentation to support ADL coding/level billed
- ❑ A COT/OMRA assessment to reflect changes in therapy intensity. (*When not provided, pays default rate from beginning of COT observation period.)*
- ❑ Per CMS policy, only the time requiring the skills of a therapist can be counted on the MDS. Only 15 minutes of e-stim is allowed to allow for equipment set up.
- ❑ A PPS Assessment. (*The Assessment cannot be created once a resident has discharged*.)
- ❑ PDPM audit validates billed case-mix adjusted components, each having their own associated case-mix indexes and per diem rates. Each character is determined by the following components:
  - PT: Clinical Category, Functional Score

- OT: Clinical Category, Functional Score
- SLP: Presence of Acute Neurologic Condition, SLP-related Comorbidity and Cognitive Impairment, Mechanically-altered Diet, Swallowing Disorder
- Nursing: Same characteristics as under RUG-IV
- NTA: NTA Comorbidity Score

❑ Level of Care reviews completed when applicable.

Audit Criteria-Durable Medical Equipment DME):

❑ Home Infusion Therapy (HIT) supplies are often included in DME Audits.

❑ Audits review all pertinent records to ensure correct billing.

- Subsequent Claims: The perspective of time permits for review of Episodes of care – such as DME Rentals and Supplies
- Patient History: Patient diagnosis and care as delivered over time & across claim types

❑ Audit Reviews:

- Physician Orders
- Proof of Delivery
- Correct Coding/Units
- Duplicative Equipment
- Certificate of Medica Necessity
- Refill Requirements
- Continued Medical Need/Use
- LCD Specific Categories
- Repairs/Replacement

❑ Suppliers are responsible for monitoring utilization of DMEPOS rental items and supplies.

❑ For ongoing supplies and rental DME items there must be information in the beneficiary's medical record to support that the item continues to be used by the beneficiary and remains reasonable and necessary. Information used to justify continued medical need must be timely for the DOS under review.

REFERENCES:

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https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c10.pdf

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c07.pdf

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107_appendixtoc.pdf

http://www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/Title42/42cfr484_main_02.tpl

ATTACHMENTS:

REVISION LOG

REVISION TYPE	REVISION SUMMARY	DATE APPROVED & PUBLISHED
Annual Review	No Changes	01/18/22
Annual Review	Adding PDPM language to the SNF audit details. Adding PDGM language to the HH audit details. Adding DME language specific to Medicare as we now have live DME audits in Medicare markets.	01/19/21
Annual Review	Clarity added to all sections.	12/5/2023
Review/Revise	Added wording related to technical denials.	2/20/2024
Annual Review	No Changes	2/10/2025

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, the Company's P&P management software, is considered equivalent to a signature.