

## **“Oh No, Not Again!” TPL Returns to Maryland Judith M. Schiavi, CPA, MBA**

At last month's liaison meeting between State of Maryland and industry representatives, William Derbyshire of the Division of Recoveries announced that the State would once again begin the Third Party Liability (“TPL”) audit process.

The purpose of TPL audits is to ensure that Maryland Medicaid is the payor of last resort, therefore the audits are designed to identify credit balances and overpayments that need to be returned to the State.

Many of us who were around for the first TPL audits that began in January of 2002 have “not so fond” memories from 2002 and 2003. And considering the economic hardships under which we currently operate, it does seem that this reappearance is particularly ill timed. Facilities have been slashing budgets to continue to provide quality care to their residents, and these audits will likely involve both a large time commitment and a potential financial hardship when few dollars are available.

While there are some differences between that initial TPL and the process described to us a few weeks ago, much will sound familiar.

### ***So, what will be the same?***

- The audit contract is held by the same contractor as the prior audits, Health Management Systems (“HMS”), although they will not be subcontracting to CDR and Associates. So the individual auditors will be different, but the audit process will be pretty much unchanged.
- You will receive a letter in the mail notifying you that your time has come. An entrance conference will be held to identify the specific reports you must provide to the auditors. As with the prior audits, you will be providing the following documentation:

1. A complete census report (covering all payor types, even non Medicaid)
  2. A current aged accounts receivable report
  3. A financial history report for each Maryland Medicaid recipient
- You will receive two reports from the auditors, a “Claims Overpayment Report” and a “Patient Resource Overpayment Report”. You will have 30 days to review and respond.
  - After the auditors have reviewed your response, you may receive a “Needs More Information Report”. You will have 14 days to review and respond.
  - Final reports will be sent to the facility. You will have 10 days to review and contact the auditors if you need an exit conference.
  - Payment plan options will be available.

### ***And, what will be different?***

- The length of the audit period, for starters. The initial TPL audits covered a six year period, the new TPL will be covering four years. A facility's four year audit period will be based upon the date of receipt of its audit scheduling letter. The six months immediately prior to the audit will be not reviewed. Therefore, if your facility receives its letter in July of 2010, we would expect your audit period to cover January 2006 through December 2009.

### **Also In This Issue:**

- ◆ Part B Fee Schedule payments reduced.
- ◆ RUG IV or Not?
- ◆ Medicare timely filing changes

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*(continued)*

***And, what will be different? (cont.)***

- Audit findings will come at a cost, specifically a 12% fee (to reimburse the auditors) over and above the identified overpayment. This fee was first introduced by the State in July 2004 via Transmittal No. 60.
- Documents are expected to be submitted electronically as the auditors will be working out of state. No more large boxes with hundreds of copies (except for your own records).

***What can I do to prepare?***

1. Locate your records- seriously. You'll need to provide everything listed on page 1 to the auditors so that they can present you with their initial findings, but that is only the beginning. There are also additional records that you need to dispute those findings. These might include any or all of the following:
  - a. Patient financial folders including insurance denials and NOE's
  - b. Cash receipts and remittances
  - c. Write off support
  - d. Abandoned property reports
  - e. Recent patient assessment adjustments
  - f. Resident trust information
  - g. Bank statements and cancelled checks
  - h. Hospice contracts
  - i. Adjustment reports filed with the State (ARFs)
2. Print your aging right now and start researching any obvious credit balances.
3. Consider your access to a scanner and an adobe program that will put page numbers on your documentation submission.

***If the audit only uncovers money that doesn't belong to the industry, why should we be upset about this process?***

The industry in good faith worked with the State to outline a third party liability audit process that would

give the State the results it needed without the overwhelming costs and time constraints of the first TPL audits. This quarterly self reporting process was outlined in COMAR 10.09.10.30. The State began working on putting this process in place then stopped moving forward with it when they experienced difficulty with the internet portal and turnover in the Division of Recoveries. Providers were told to stop sending in credits and to wait for further instruction. We are disappointed that the State intends to move forward with an audit process that is in direct contrast to existing Maryland regulations and hope that the associations will be able to intervene on the industry's behalf.

Meanwhile, another meeting with the State and audit contractors has been scheduled, so begin preparing your facility and watch for additional instruction. We were told that the Division of Recoveries intends to begin issuing audit letters soon.

Need help planning for your TPL audit? Contact Judy Schiavi at [jschiavi@schia-vi-wallace.com](mailto:jschiavi@schia-vi-wallace.com)

**Part B Fee Schedule Amounts  
in Limbo Again**

*By Dawn L. Rowe CPA, MBA, CPC*

The third extension to eliminate the (21.2%) decrease to the Part B fee schedule payment amounts has expired. The Continuing Extension Act of 2010, enacted on April 15, 2010 extended the zero percent update to the 2010 Fee Schedule through May 31, 2010. Fee Schedule Amounts are usually updated every January 1. On December 22, 2009 President Obama signed into law the \$636.3 billion Department of Defense Appropriations Act of 2010 which included a provision to update the Medicare Physician Fee Schedule conversion factor to 0% for the period January 1, 2010 to February 28, 2010. This was further extended to March 31, 2010 by the Temporary Extension Act of 2010, and finally through May 31, 2010 by the Continuing Extension Act.

In an email dated May 27, 2010, CMS notes that it believes Congress is working to again avert the negative update effective June 1, 2010, and has instructed its contractors to hold claims for services provided

under the fee schedule for the first 10 business days of June for dates of service beginning June 1, 2010 and later. CMS also wrote that this should have no impact on cash flow since “clean” electronic claims are currently not paid any sooner than 14 days after the date of receipt (29 days for paper claims).

As of this writing, there has been no Congressional action to further postpone the payment reduction. Therefore, it appears the 21.2% payment reduction is in effect. We will attempt to note any updates on our website at [www.schiavi-wallace.com](http://www.schiavi-wallace.com) under “What’s New”.

### **Health Care Reform Complicates October 1 SNF PPS Update** *By Dawn L. Rowe CPA, MBA, CPC*

Normally by now we’d have an idea of what the SNF PPS RUG rates will look like beginning October 1, 2010 since a proposed rule is usually published in May. As rumors flew regarding the status of the RUG-IV implementation originally slated to be rolled out in conjunction with the MDS 3.0 this October, but delayed as a result of the Patient Protection and Affordable Care Act (ACA), also known as Health Care Reform, CMS finally issued an email on May 24, 2010 addressing the issue.

#### *The Grouper Problem*

In the email sent to those subscribed to the CMS FFS provider listserv (go to [http://www.cms.gov/prospmedicarefeesvcpmtgen/downloads/Provider\\_Listservs.pdf](http://www.cms.gov/prospmedicarefeesvcpmtgen/downloads/Provider_Listservs.pdf) to subscribe), CMS explained the dilemma. While the ACA delayed the RUG-IV implementation by one year, it mandated that MDS 3.0 be implemented as planned. Further, the proposed changes to concurrent therapy and the elimination of the Medicare look-back to the hospital stay for certain services reported in section P1a are also to be applied as originally planned. The problem? There is an existing software grouper that uses MDS 2.0 data to classify residents to the current RUG-53 groups, and an

existing grouper that can use MDS 3.0 data to classify residents to the proposed RUG-66 groups, BUT not a grouper that can use MDS 3.0 data and classify residents to the current RUG-53 groups.

#### *The “Interim” Solution*

While CMS takes the time to build the MDS 3.0/RUG-53 grouper, which apparently cannot be done in time for the annual October 1 payment update, they intend to “apply interim payment rates” using MDS 3.0 AND the new RUG-IV system as proposed in the August 11, 2009 Federal Register. Once the grouper is in place, they plan to retroactively adjust the rates to reflect the new “hybrid RUG-III”. They state that this approach will allow CMS to continue to pay providers with “the least amount of disruption”. The rates will be published in an upcoming Federal Register issuance, and further guidance will be issued in the near future.

#### *Or Maybe Not...*

Lastly, CMS notes that there is legislation currently pending in Congress that could repeal the provision in the ACA delaying RUG-IV by one year, and that this would therefore eliminate the need to retroactively the payment rates. Perhaps this is the only solution that would truly provide the least amount of disruption.

Stay tuned! CMS is holding a national provider call with Q&A on this issue on June 23, 2010. To register go to <http://www.eventsvc.com/palmettogba/062310>. If you are unable to attend a transcript and MP3 audio file of the call will be available at least one week after at [http://www.cms.gov/SNFPPS/02\\_Spotlight.asp](http://www.cms.gov/SNFPPS/02_Spotlight.asp).

**Note to users:** All information provided is of a general nature and is not intended to address the circumstances of any particular individual or entity. Although we endeavor to provide accurate and timely information, there can be no guarantee that such information is accurate as of the date it is received or that it will continue to be accurate in the future. No one should act upon such information without appropriate professional advice and after a thorough examination of the facts of the particular situation.

**Reminder:  
Maximum Period for Submission of Medicare Claims Reduced  
to Not More than 12 Months**

As a result of the Affordable Care Act (ACA), claims with dates of service **on or after January 1, 2010**, received later than one calendar year beyond the date of service will be denied by Medicare. For more details read the articles at <http://www.cms.gov/MLN MattersArticles/downloads/MM6960.pdf> on the CMS website.

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