

ADRs and Denials

May 2016 Subscriber Webinar

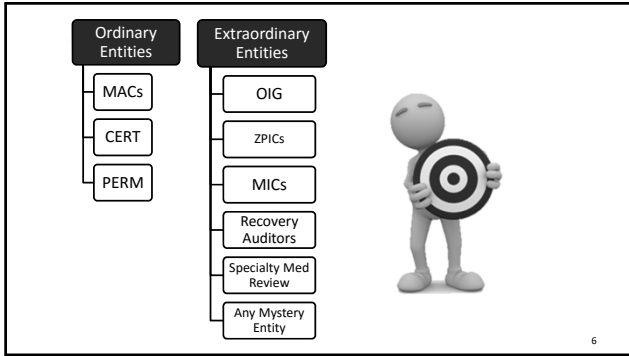
What We'll Cover

- A brief review of the Medical Review process and what it means to your hospice
- An organized and methodical process for responding to Medical Review
- A plan to promote organizational readiness for Medical Review

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CMS Improper Payment Reduction Efforts

- Top priority for the CMS: ensure that payment is made only for those medical services that are reasonable and necessary
- Preventing Medicare improper payments requires
 - Active involvement of every component of CMS and
 - Effective coordination with its partners including various Medicare contractors and providers
- CMS and its contractors have very broad authority to perform medical review



Areas of Governmental Focus

- Length of stay by site of service
- Long length of stay
 - Impact Act - requires MR of hospice cases >180 days in hospices with preponderance of such patients
- GIP by site of services
- Live discharges
- Burdensome transitions
- Leakage
- Care planning
- Skilled visits at end of life

Remember the data is available and shared!

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MAC Reviews/Edits

Service Specific (from different providers)

- Usually a 100 claim sample based on a specific service
- Claims randomly selected
- MAC medical review department will publish an article notifying providers when a service-specific review is initiated and an article with results

Provider Specific Edits

- 20 to 40 claim samples based on claims from the selected provider
- Providers notified by letter at start
- Duration of review and % of claims reviewed depends on charge denial rate (% of claim \$\$ denied)

Beneficiary Specific Edits

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Recent MAC Edits

- NGS J6 (April 2016)
 - Provider specific audits
 - Increase in utilization compared to prior year
 - Annual percentage change in reimbursement of > 30%
 - LOS > 180 days
 - Increased average use of GIP
 - No wide-spread probes
- NGS JK (April 2016)
 - Widespread probe LOS>365 days

Possible Results of MAC Medical Review

- Depending on your charged denial rate
- Medical review discontinued with no further action - generally denial rate <15%
 - Medical review discontinued with education for provider; possibly subject to another probe in 6 months
 - Targeted medical review (i.e., conduct pre-payment review on a percentage of claims) for at least a quarter
 - Written Corrective Action Plan requested from provider and prolonged review
- If little progress, various sanctions available
- Referral to ZPIC
 - Comprehensive (post pay) medical review and/or
 - Withholding of payment
 - Possible exclusion from program

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Effects of Medical Review

- Resource utilization
- Can significantly affect cash flow
 - Affects profitability
 - Not paid for the services provided under the period of review
- Sequential billing
- Census
 - Discharges
 - Eligible patients not admitted
- Targeted Medical Review
 - Its draining!



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*Medical Review
Requests/Additional
Development Requests
(ADRS)*

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Usual Sequence of Events

- Identification of provider / claims
- Request for records
- Tracking submission of records
- Review
 - Technical issues
 - Eligibility
- Communication of Decisions
- Appeals Process

Getting the Requests

- Starts with the correct address
- Identifying the correspondence as a request



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What's in an Additional Request (ADR) Letter?

- Reason** your claim was selected
- What** actions you need to take
- When** you need to reply
- Consequences** of not replying
- Instructions** for replying
- Contractor **contact** information

Medicare Review Requests

Understand who the request is from

- Review the letter, deadlines, what to include

MACs

- Ensure a process is in place for monitoring claims selected for review and responding to ADRs
 - Monitor claims inquiry system (FISS System) to determine ADR requests and track ADR responses
 - Use a spreadsheet to track deadlines for responses and payment/denial dates
 - Check the system for ADR claims to confirm receipt of the medical record

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Keep This In Mind

The reviewer

- Does not know your patients
- Does not know your documentation system
- Does not sit in on your IDG meeting
- Most likely has not worked in hospice

Make it simple as possible for reviewer

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Additional Development Requests

- Designate a point person to coordinate efforts
- Designate a team or point person to review records before submission
- Know your MAC requirements
- For other entities-read the correspondence closely

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*Timelines to Submit Records**

Contractor	Timeline: Prepayment	Timeline: Postpayment
MAC	45 days from date of request	45 days from date of request
CERT	45 days from date of letter	45 days from date of request
RA	N/A	45 days from date of request
ZPIC	45 days from date of letter	30 days

*Always read the instructions carefully

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Preparing the Packet

- Include all documentation noted in your MAC's ADR checklist or other entities request
- Use your MACs LCDs when reviewing the documentation and creating the cover letter
- Determine if there is any additional supporting documentation for eligibility that should be submitted
- Include
 - Everything that is requested for the period under review
 - Anything outside the period requested that helps support the eligibility

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What They Will Look At

Payment requirements

- Technical
 - Beneficiary Election statement
 - All technical components of certifications/recertifications
 - Plans of care
- Eligibility
 - Medicare coverage guidelines
 - Documentation supports the services billed
 - General inpatient
 - Continuous Home Care
 - Physician visits

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The Technical Side

Have to pass this review first!

- Hospice Notice of Election
- Certifications and Recertifications
- Plan(s) of care
- Signatures
- Signature dates

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Notice of Election - The Elements (418.24(b))

1. Hospice Name
2. Effective date of election
3. Individual's (or representative's as applicable) acknowledgement of full understanding of palliative rather than curative nature of hospice services
4. Individual's (or representative's as applicable) acknowledgement that the individual understands certain Medicare services are waived by the election
5. Identification of attending physician and acknowledgement that identified physician was his or her choice
6. Individual's (or representative's as applicable) signature

The Certifications

All applicable components that cover the period under review

- Statement(s) of 6 months or less
- Narrative(s)
- F2F(s) where applicable

Remember a 30-day period under review may have 2 benefit periods

- Send certifications to cover both
- For longer periods under review it may be more

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Plans of Care

Remember the period under review may have more than one plan of care

- Initial plan of care developed before services provided if period under review includes admission
- Every 15 days at minimum
- Send all plans of care which cover the period under review
- All documents that make up the plans of care
- Signatures or other documentation which shows involvement of the IDG

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Signatures

- Signatures must be legible
- If the signatures are not legible and were not signed over a printed name, include a signature log or attestation statement from the signer
- Details : MLN-Complying with Medicare Signature Guidelines

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Recordkeeping Principles

Amendments, Corrections or Addenda

1. Clearly and permanently identify any amendment, correction or delayed entry as such
2. Clearly indicate the date and author of any amendment, correction or delayed entry
3. Clearly identify all original content, without deletion
4. Paper Medical Records corrections
5. Electronic Health Records (EHR) corrections
6. Make sure your policy addresses

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Supporting the Claim

Include any additional documentation outside of the period under review that helps support eligibility (MACs)

- Notes
- Outside clinical records
- Recertification summaries
- F2F documentation
- Narratives
- GIP in contract bed-include facility record
- Orders

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The Cover Letter - To Do or Not?

MAC ADRs

- Not required, but maybe helpful as a roadmap to point out / highlight documentation and events
- Letter to clarify issues concerning your documents
 - Explanation of what your documents are called (i.e., plan of care is called IDG Summary and plan of treatment, physician certification is contained in documents x, y, z) that correspond to their requests
- Summarize the clinical information supporting a terminal prognosis
 - Make sure there is documentation in the clinical record to support the letter

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Documentation Must Show

History, illness progression, recent changes, current status

Acuity or the trajectory that supports the 6-month prognosis

Utilize Local Coverage Determinations (LCD) when available

To draw attention to important information

- Do not highlight
- May use brackets, such as [] or { }, asterisks (*) or underlined text in the documentation
- Should not give appearance of altering the documentation

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The Cover Letter – To Do or Not?

A tip from Reinhart Law regarding ZPIC and MIC document requests:

- May consider letter to clarify issues concerning your documents
 - Explanation of what your documents are called (i.e., plan of care is called IDG Summary and plan of treatment) that correspond to their requests
- Do not include any advocacy pieces
 - Do not know what ZPIC and MIC areas of focus are
 - Save the effort to respond to any denials

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Putting the Packet Together

1. MAC ADR letter
2. Hospice cover letter
3. Death note if applicable
4. Hospice notice of election
5. Certifications/recertifications
6. Any relevant outside clinical documentation
7. Medication profile

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Putting the Packet Together

Arrange remainder in chronological order (reads like a book)

- All documentation (notes, assessments, plans of care, orders, summaries from earliest to latest)
- If you have continuous care, put the continuous care log and a note of when CC began & ended -- then follow with the notes.
- If the patient was in contract bed for general inpatient, provide at least the discharge summary from the facility
 - Include the MARs for medications administered
 - Rest of facility documentation would generally be helpful
- Death Note (if applicable)

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The Final Product

Check for technical issues

- Certifications/recertifications
- Narratives / F2F Encounters
- Attestations
- Plans of care
- Legible signatures

And then check again!

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The Final Product

- Paginate records
- Keep a complete copy of what you submit
- Track when sent and received

- Use what you learned in reviewing and preparing records
 - Do not wait until you get results from Medicare contractor

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Denials and Appeals

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Medical Review Top Denial Reasons Across MACs

- Does not support a terminal prognosis
- F2F requirements not met
- Physician narrative statement not present or not valid
- Untimely certification/recertification
- Lack of valid certification
- No plan of care submitted or invalid/not updated at least every 15 days by IDG
- Election statement incomplete, missing, untimely
- Documentation not received timely or no response to ADR
- GIP not reasonable and necessary

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A Denial, Now What?

- Determine reason for denial
- Consider appeal
- Prepayment denials: release billing for that patient one claim at a time
 - Don't submit the next one until first one paid
- Medical director visit to support continued eligibility
- Obtain additional documentation supporting eligibility

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Five Levels of Appeal	Who	Time Frames to Appeal	Issue Decision (generally)
1. Redetermination	MAC but different than those who made initial determination	120 days	60 days
2. Reconsideration	Qualified Independent Contractor (QIC)	180 days	60 days
3. ALJ	Administrative Law Judge	60 days	90 days
4. Medicare Appeals Council	Medicare Appeals Council	60 days	90 days
5. U.S. District Court	U.S. District Court	60 days	Varies

OMHA-Alternative to ALJ Hearings

- Pilot alternative dispute resolution process
- Request for hearing must have been filed on or before December 31, 2015
- Amount of each individual claim must be \$100,000 or less
- At least 50 claims must be at issue and at least \$20,000 must be in controversy

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Be Proactive & Prepared

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The Proactive Plan – Your Compliance Program

- Know your risks
 - Know your data comparisons
 - Compliance program audit work plan
- Implement a plan to reduce risks
- Know who the requests may come from
- Have a good plan to respond to medical review
- Have a plan to track

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Know Your Risks

Ongoing reviews of own records

- Technical components
- Clinical eligibility
- Consistency
- Application of LCDs
- Admission
- Recertification

Make sure you apply the tools properly and consistently

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Medical Review Readiness Assessment Tool

		Action		Notes / Action Plan
		Yes	No	
The Team	Print person and back-up identified			
	ADR team identified			
	ADR team trained			
On-going review	Process to check FGD (SAC)			
	Process to identify hard copy correspondence and to forward immediately			
	EMR: process to print records and scan paper; process to scan records			
Medical Records & Data Management	Process to put records in order and check for all required documentation			
	Process to burn to CD or submit electronically as applicable			
	Tracking data base designed & tested			
Internal Controls	Review of technical and clinical documentation			
	Process to determine need for cover letter and who writes the letter			
	Correct address for mailing or faxing			
Program Tracking	Confirmation of receipt			
	MARC checking status of payment or denial			
	Internal notification process (leadership, sales, ADR team)			

Have a plan in place and ready to go

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Have a Plan in Place to Track

- Date of ADR request
- Date submitted
- Total billed claim
- Amount paid
- Redetermination due date
- Date submitted
- Reconsideration due date
- Date submitted
- ALJ due date
- Date submitted



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Actions of The Prudent Hospice

- Prepare-medical review is coming your way
- Know your numbers – how might your program stand out in data analysis and what steps are you taking to address it
- Have the technical components flawless
- Know how well your documentation supports eligibility - don't wait for Medicare to tell you
- Integrate into Compliance Program
- Have a process in place to be able to respond to ADR requests timely
- Use what you learn in reviewing and preparing records

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The information enclosed was current at the time it was presented. This presentation is intended to serve as a tool to assist providers and is not intended to grant rights or impose obligations.

Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services.

Resource Sheet
 Subscriber Webinar: ADRs & Medical Review
 May 2016

Medicare Program Integrity Manual (PIM), CMS Publication 100-08	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019033.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending
Contractors at a Glance	http://www.cms.gov/Outreach-and-Education/Medicare-Learning-network-MLN/MLNMattersArticles/Downloads/dwnlds/SE1123.pdf
Medicare Claims Review Program booklet	http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MCRP_Booklet.pdf
Medicare Appeals Process	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedicareAppealsProcess.pdf
Complying with Medicare Signature Requirements	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Signature_Requirements_Fact_Sheet_ICN905364.pdf
Hospice Fundamentals Subscriber Webinars	<ul style="list-style-type: none"> • Medicare Payment and the Plan of Care (August 2015) • Certification/ Recertification Process: No Room for Error (March 2016) • The Clinicians Connection To Eligibility: Assessing and Documenting for Decline (February 2016)



MAC Medical Review Preparation Wise Practice Recommendations

NOTE: If using an electronic medical record (EMR), adapt these recommendations to accommodate how your medical record prints, what comprises your IDT Plan of Care, comprehensive assessment, and certification and recertification process.

1. Remember that the people that will be reviewing your documentation do not know your documentation system and may not be very familiar with hospice, may never have seen a hospice patient or cared for someone at the end of life. All that they know about the patient is what they read in your record. What may seem clear to us is not necessarily so to the reviewer; your challenge is to make the compiled records as simple as possible to follow. Let the record tell the story of the course of care as it paints the picture.

2. Read your MAC's (or other Medicare or Medicaid contractor) instructions for submitting ADRs; they may be very specific. Use the guidelines in this document in conjunction with those instructions.

3. The reviewers evaluate technical eligibility before medical eligibility. In order to get to the next step of the review process, these technical areas must be complete and correct.

- a. Hospice Notice of Election (*with all required components*)
- b. Certifications and recertifications (all applicable components) covering the period under review
 - i. Statement(s) of life expectancy of 6 months or less
 - ii. Narrative(s)
 - iii. F2F(s) where applicable
 - iv. Remember the period under review may span 2 benefit periods. Make sure to send certifications to cover the entire period.
- c. Plans of care (all applicable components) covering the entire period under review
 - i. Documentation demonstrating IDG involvement in each plan of care
 - ii. Consider including information in cover letter explaining what constitutes the plan of care, where to locate documentation of IDG involvement, and where progress or lack of progress is documented
 - iii. Remember the period under review may have plans of care which were initiated prior to the period

4. Signatures must be legible or the document will be

disregarded in review. If there is a problem with a signature on a certification the claim will be denied based on no valid certification.

- a. If the signatures are not legible and were not signed over a printed name, include a signature log or attestation statement from the signer.
- b. This applies to certification/recertification (all components), orders, plans of care, progress or visit notes, and shift notes for IPU, hourly notes for continuous care.

5. Include all documentation noted in your MAC's ADR checklist.

6. Include any additional documentation outside of the period under review to support the patient's eligibility. This may include outside clinical records of events occurring prior to admission such as hospitalizations and physician's office visit notes. Also include non-hospice provider documentation such as labs, consultations, hospitalizations as well as other hospice documentation during the period under review such as recertification summaries, narratives, orders, documentation of events which support the eligibility.

7. Compile the material in the order requested by the requesting party. If no order is specified, submit using the following sections. Label each section clearly and include a title page for each section. Consider adding a standard form which orients the reviewer to your records; specifically the documents that make up your plans of care and your complete certification and recertification process. Since forms have different titles and sometimes very different places for signatures, make sure that it is clear. Remember – they see records from hundreds of hospices and components of each may vary. Don't make them guess at what and where yours are. For those with EMRs, consider including your policy or a statement on what is considered an electronic signature and how that is controlled.

- a. ADR Letter from MAC. It is what they use to put the record into their tracking system.
- b. Cover letter which summarizes the patient and supports payment of the claim. If possible, have



HOSPICE FUNDAMENTALS

KNOWLEDGE • EXPERTISE • COMMON SENSE

MAC Medical Review Preparation Wise Practice Recommendations

NOTE: If using an electronic medical record (EMR), adapt these recommendations to accommodate how your medical record prints, what comprises your IDT Plan of Care, comprehensive assessment, and certification and recertification process.

your medical director involved and sign the letter. If not, it should be signed by a clinical leader. Anything in the letter must be supported by documentation in the record.

- c.** Section 1: Hospice notice of election
- d.** Section 2: Certifications/recertifications (all components)
- e.** Section 3: Any current outside clinical documentation supporting eligibility (i.e. labs, hospitalizations prior to admission, etc.). Make sure this is pertinent information; more is not necessarily better.
- f.** Section 4: Medication profile/list
- g.** Section 5: The rest goes in chronological order so that it reads like a book
 - i.** All documentation means all disciplines notes, assessments, plans of care, orders, summaries, MARs, ABNs from earliest to latest (a note about plans of care: you need to include all plans of care for the period under review which may frequently be more than 2 depending on timing).
 - ii.** If the period under review includes continuous care (CC), include the CC log and a note of when CC began & ended; follow with the notes. Include any physician orders for changes in medications and treatments and the plan of care update for CC.
 - iii.** If the patient was in a contracted bed for general inpatient care, include a copy of all notes and orders for the care generated by the contracted provider.
 - iv.** If the patient revoked or was discharged during the period under review, provide a copy of the revocation form (if applicable) and the discharge note.

8. For printed EMR and paper documentation, put them all in order, review and review again.

- a.** Review everything at least twice, and then number/Bates stamp the pages.
- b.** Put in the right order (right side up, all tops facing the same way). If two-sided forms, then make sure you are using the scanner to capture both sides. Remove duplicate documentation and fax cover sheets that contain no important documentation.

c. If you have some forms which are two-sided and some which are not, consider converting them to one-sided during the copying process so you can run the whole “book” through at once flawlessly.

d. Do not staple documents.

e. Check with your MAC for approval and instructions on if and how you can submit via DVD/CD.

9. No matter which format you are using, QA to assure that all the documents are there, legible and that it makes sense.

10. Electronic submission of ADRs is possible. Refer to the esMD webpage for instructions. www.cms.gov/esmd

11. Make a duplicate for your files

12. Use care when mailing records

- a.** For paper records, send each record in a separate mailing or, if mailed in the same box, include a manifest of the records with each record bull dog clipped so it is clear what records are what.
- b.** For DVD/CDs, put a list of ADRs at the beginning of the DVD/CD.
- c.** Use a mailing method that provides a traceable proof of delivery.



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Medical Review Readiness Assessment Tool

	Action	Yes	No	Notes / Action Plan
The Team	Point person and back-up identified			
	ADR team identified			
	ADR team trained			
On-going Process	Process to check FISS (MACs)			
	Process to identify hard copy correspondence and to forward immediately			
Record Preparation & Tracking: Technical	EMRs: process to print records and scan Paper: process to scan records			
	Process to put records in order and check for all required documentation			
	Process to burn to CD or submit electronically as applicable			
	Tracking data base designed & tested			
Record Preparation: Clinical	Review of technical and clinical documentation			
	Process to determine need for cover letter and who writes the letter			
Progress Tracking	Correct address for mailing or faxing			
	Confirmation of receipt			
	MACs-checking status of payment or denial			
	Internal notification process (leadership, billers, ADR team)			