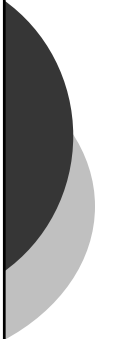


## Medicare Administrative Contractors and the Medical Review Process

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Ask the Experts  
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## Medicare Administrative Contractors (MAC) Audits

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- Intended to identify incorrect payments and educate providers on correct reporting of services
- Usually triggered by data analysis or complaints/referrals
- Have authority for pre-payment and post-payment review, but historically have used pre-payment review (Additional Development Requests-ADR requests)
- Process referred to as Progressive Corrective Action (PCA)



## Medical Review

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### Potential MAC targets (besides Palmetto NCLOS reviews)

- Hospices who have exceeded the hospice cap and not been on review within last year
- 100% beneficiaries on service for > 1 year
- Discharge and readmission patterns
- Continuous home care & general inpatient



## Progressive Corrective Action

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### Widespread probe

- Random sampling of all providers' billing of the service in question
- 100 total claims selected for review



## Progressive Corrective Action

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### Provider specific probe

- Will be notified
- Sampling of 20-40 claims billed (ADRs)
- Pre-Pay Review
  - Claims under review held for payment until a determination has been made
    - With sequential billing, no claims for that patient can be paid until the claim under review is completed
  - If the review results in a denial, all subsequent claims for that patient may be reviewed until a claim is paid
    - Beneficiary specific edit



## Medical Review Results

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- Determination of whether the medical review is discontinued or resumed is based on data analysis of the reviewed and processed claims
- Result of the data analysis is expressed as a percentage and is identified as the charge denial rate (CDR)



## Charge Denial Rate

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Total \$ charges denied on the number  
of claims reviewed

Divided by

Total \$ charges on the number of  
claims reviewed

Multiplied by 100= CDR



## Example

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O25 claims X 30 days @ \$160 / day  
= \$120,000 billed

O4 claims X 30 days @ \$160 / day =  
\$19,200 denied

$$\mathbf{\$19,200 / \$120,000 \times 100 = 16\% \text{ CDR}}$$



## Possible Results of MAC Medical Review

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- 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)
- Written Corrective Action Plan requested from provider and prolonged review
  - If little progress, various sanctions available (e.g., referral to ZPIC, possible exclusion from program)



## ADRs

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- May be appropriate to ask MAC to reduce number of ADRs pulled
  - If census is small
  - If ADR requests > 40



## Medical Review - What They Will Look At

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### Payment requirements

- Election
- Certification/recertification
- Eligibility
  - Has a prognosis of 6 months or less
  - General inpatient
  - Continuous Home Care
- Plans of care



## Medical Review Top Denial Reasons (Palmetto GBA April - June 2011)

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1. Documentation does not support six month terminal prognosis
2. Physician Narrative statement not present or valid
3. No plan of care
4. No response to ADR
5. No Certification for dates billed





## Medical Review Top Denial Reasons

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6. Subsequent Certification Not Timely
7. Initial Certification Not Timely
8. Hospice Continuous Care Hours Reduction
9. No Valid Election Statement Submitted
10. Continuous Care Hours Not Documented



## You Have ADRs-Now What?

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Wise Practice Recommendations  
(Handout)



## MACs

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They want to pay the claim

But they need you to have the  
documentation that supports  
payment



## Additional Development Requests

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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 for the ADR





## Additional Development Requests

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- Designate a point person to review records before submission
- Know your MAC requirements
  - Notification letter
  - DDE screen



## Best Defense is a Good Offense

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- Ongoing reviews of own records
  - Consider consultant services
- Consistency
- Know the LCDs
- Apply the tools properly and consistently
- Education
- Performance Improvement Project



## ADRs Submitted-Now What?

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- May have a few months before know CDR and if continue to targeted medical review
- Implement process improvement immediately
  - What did you discover?
  - Basics
  - Education
  - Monitoring and auditing
  - Accountability



## ADRs Submitted-Now What?

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- Begin documenting objective data now on all patients
  - Weights if you can
  - MAC
  - Amount of assistance required for ADLs
- Work with your physicians to improve quality of F2F documentation and narrative
- FAST – is it accurate
- PPS – is it accurate



## A Denial, Now What?

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- Review reason for denial
- 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
- Start appeal process



## Contact Information

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## MAC Medical Review Preparation – Wise Practice Recommendations

**NOTE:** For hospices with an EMR, these recommendations need to be adapted to how your medical record prints, what comprises your IDT Plan of Care and comprehensive assessment, and what comprises your certification and recertification process. If you are on a paper system, it is generally more straightforward.

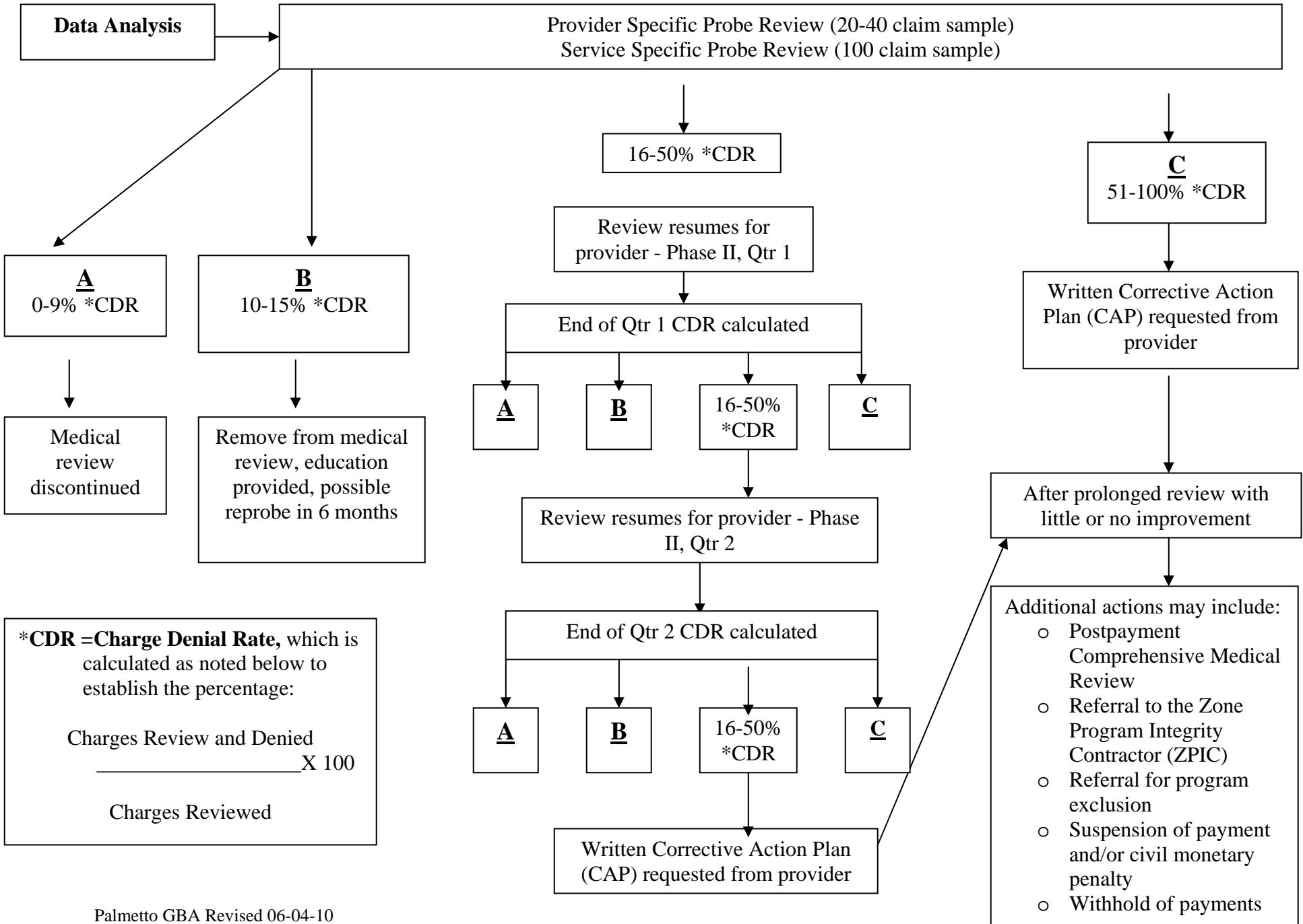
1. Remember that the person that will be reading your documentation does not know your documentation system and may not be very familiar with hospice, may never have seen a hospice patient or cared for someone at the end of life. They do not know your patients and do not sit in on IDG or participate in any kind of communication outside what they read in your records. What seems simple to us is not to the reviewer. Make it as simple as possible for the reviewer to follow the course of care – the record should tell a story as it paints the picture.
2. The reviewers will first look for technical eligibility before they review for medical eligibility. You need to have this complete and correct to get to the next steps in the review process
  - a. Hospice Notice of Election (with all required components)
  - b. Certifications and recertifications (all applicable components) that cover the period under review
    - i. Statement(s) of 6 months or less
    - ii. Narrative(s)
    - iii. F2F(s) where applicable
    - iv. Remember the period under review may have 2 benefit periods. You have to send certifications to cover both.
    - v. Use the recertification checklist Hospice Fundamentals tool
3. Signatures must be legible or the document will be disregarded in review – which means that 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 includes certification/recertification (all components), orders, plans of care, progress or visit notes, shift notes for IPU, hourly notes for continuous care.
4. Include all documentation noted in your MAC's ADR checklist.
5. Include any additional documentation outside of the period under review to support the patient's eligibility. This may include outside clinical records prior to admission such as hospitalizations, physician's office visit notes and your hospice documentation such as recertification summaries, narratives, orders, documentation of events which support the eligibility.
6. Put your documentation in the following order with the following section headings. Label each section clearly and include a title page for each section.
  - 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. Have your medical director review and sign the letter if possible. If not, it should be signed by a clinical leader.
  - c. **Section 1:** Hospice notice of election
  - d. **Section 2:** Certifications/recertifications
  - e. **Section 3:** Any current outside clinical documentation supporting eligibility (i.e. labs, hospitalizations prior to admission, etc.)
  - 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 notes, assessments, plans of care, orders, summaries 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 you have continuous care, put the continuous care log and a note of when CC began & ended -- then follow with the notes. It is preferable to include a physician order or the plan of care update (signed by MD) to initiate CC.
    - iii. If the patient was in contract bed for general inpatient, you must provide the discharge summary from the facility and it would be most beneficial to provide a copy of all notes and orders for the care provided under contract.
7. If you are going to send electronically there may be different ways to prepare depending on your EMR system and depending if you are on paper documentation
  - a. If your EMR can print to read like a book, go see your IT department to determine the best way to export
  - b. If your EMR does not print easily, then print all documents as noted above and put in the above order prior to scanning.
8. For printed EMR and paper documentation, put them all in order, review and review again.
  - a. Review everything at least twice, then number the pages
  - b. Put in the right order (right side up, all tops facing the same way. If 2 sided forms, then make sure you are using the scanner to capture 2 sides).
  - c. If you have some forms which are 2 sided and some which are not, consider copying them 2 sided to one sided so you can run the whole "book" through at once flawlessly.
9. QA either CD or paper to make sure all the documents are there, legible and that it makes sense.
10. Make a duplicate for your files
  - a. CD for electronic
  - b. Paper for paper
11. Mail so you can track receipt
  - 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 CDs, put a list of ADRs at the beginning of the CD.
  - c. Mail ADRs so receipt received can be tracked.



**HOSPICE FUNDAMENTALS**

KNOWLEDGE • EXPERTISE • COMMON SENSE

# Progressive Corrective Action (PCA) Decision Tree



**\*CDR = Charge Denial Rate**, which is calculated as noted below to establish the percentage:

$$\frac{\text{Charges Review and Denied}}{\text{Charges Reviewed}} \times 100$$