

ADRs and Denials

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What We'll Cover

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

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CMS and Medical Review

- CMS is required to ensure that payment is made only for those medical services that are reasonable and necessary
- CMS and its Contractors have very broad abilities to perform medical review

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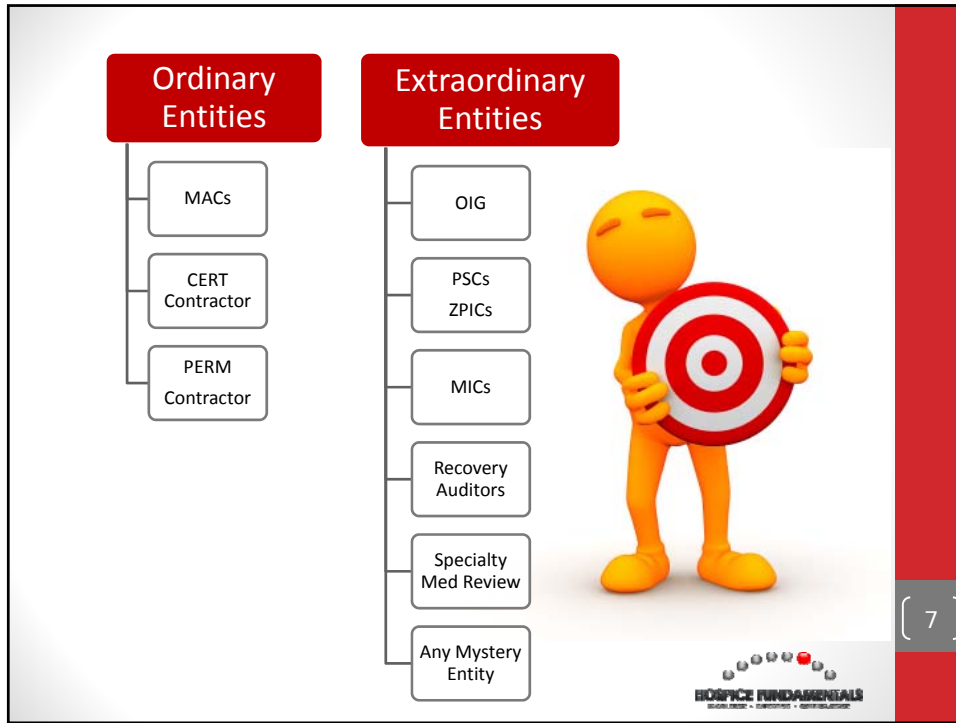


42 CFR 418 Subparts

- A. General Provision and Definitions
- B. Eligibility, Election and Duration of Benefits
- C. Conditions of Participation – Patient Care
- D. Conditions of Participation - Organizational Environment
- E. Conditions of Participation – Removed and Reserved
- F. Covered Services
- G. Payment for Hospice Care
- H. Coinsurance

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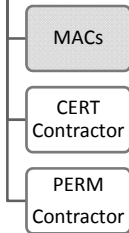




	Review Type				Purpose
	Postpay	Prepay	Automated	Complex	
MAC	(X)	X		X	Prevent future improper payments
OIG	X			X	Identify fraud
PSC	X	X	X	X	Identify potential fraud
MICs	X		X	X	Identify potential fraud
RAs	X		X	X	Detect and correct past improper payments

MAC Responsibilities

Ordinary Entities



- Process claims and make payments to providers
- Communicate changes to providers
- Provide education
- Assist providers and beneficiaries as needed
- Conduct audits and reviews
- Identify and investigate potential problems in claims submission or utilization patterns
- Make referrals to investigatory bodies as necessary



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MAC Probe Edits

Service Specific

- 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

- 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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MAC Edit Purpose

Target claims with greatest risk of improper payment

- Certain diagnoses
- Level of care
- New providers
- Length of stay
- Rapid growth in \$\$\$ billed

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MAC Edits

- National Government Services
- Palmetto GBA
- CGS
- NHIC

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MAC Medical Review Results

- Effectiveness of all edits evaluated quarterly
- Widespread probe review can result in widespread edit when high denial rate found in probe
- Hospices on provider specific probe edits will receive a letter (resume or discontinue)
 - 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 charged denial rate

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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 Top Denial Reasons Across MACs

- Not hospice appropriate/documentation does not support 6 month prognosis
- Face-to-face encounter requirements not met
- Physician narrative statement not present or not valid
- Untimely certification/recertification
 - No verbal certification (when written outside time requirements)
 - Subsequent certification not timely
 - Physician signature not dated
- Lack of valid certification
 - Lacks certification dates
 - Lacks appropriate signatures and dates
- 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



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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 for the ADR

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What They Will Look At

- Payment requirements
 - Technical
 - Beneficiary Election statement
 - Certification
 - Plans of care
 - Eligibility
 - Medicare coverage guidelines
 - Documentation supports the services billed
 - General inpatient
 - Continuous Home Care
 - Physician visits

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The Reviewer

- Keep this in mind-the MAC 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
MAC	30 days from date of request
CERT	75 days from date of letter
RA	45 days from date of letter
ZPIC	Varies-refer to the letter

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
- Obtain additional supporting documentation for eligibility
- Include
 - Everything that is requested for the period under review
 - Anything outside the period requested that helps support the eligibility

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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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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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Notice of Election – The Elements

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. Individual's (or representative's as applicable) signature

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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

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Supporting the Claim

- Include any additional documentation outside of the period under review that helps support eligibility
 - 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?

- Not required, but
 - Maybe helpful as a roadmap to point out / highlight documentation and events
- 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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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

8. Rest 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-again)

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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

- Number the pages
- Keep a complete copy of what you submit
- Track when sent and received



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A Denial, Now What?

- Determine reason for denial
- Consider appeal
- 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

The Offensive Plan

- Know your risks
- 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

- Are you an outlier?
 - LOS
 - NCLOS rates for Palmetto GBA hospices
 - Diagnostic mix
 - % patients in NF
 - GIP percentage or LOS
 - CHC percentage or LOS
 - Growth
 - Live discharges

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Know Your Risks

- Ongoing reviews of own records
 - Technical components
 - Clinical eligibility
 - Consistency
 - Application of LCDs
 - Admission
 - Recertification
 - Apply the tools properly and consistently

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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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Take Aways

- 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



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Resources

- *Medicare Program Integrity Manual (PIM)*, CMS Publication 100-08
- www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html
- *CMS Medicare Benefit Policy Manual* (CMS Publication 100-02)
 - Chapter 9 – Hospice
- <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-network-MLN/MLNMattersArticles/Downloads/dwnlds/SE1123.pdf>
- http://www.cms.gov/Outreach-and-Education/Medicare-Learning-network-MLN/MLNProducts/downloads/ContractorEntityGuide_ICN906983.pdf
- Medicare Claims Review Program booklet
http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MCRP_Booklet.pdf
- www.OIG.gov



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Do you need Compliance Certification Board (CCB) continuing education credits?

1. Download the application at:

<http://www.compliancecertification.org/Portals/2/PDF/CCEP/ccb-scce-individual-accreditation-app.pdf>

2. Attach a PDF of handouts
3. E-mail or fax to address on the application



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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)			