Nebraska Hospice and Palliative Care Partnership

Dealing With ADRs, TMRs, and Claim Denials

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Objectives

Participants will be able to:

1. Define the terms Probe Edit, Additional Development Request and Targeted Medical Review.
2. Identify the difference between *technical* and *medical* claim denials.
3. List the five (5) levels of appeals, and timelines associated with each level.
4. Identify five (5) strategies for managing the ADR/TMR process.

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Lions, Tigers and Bears… Oh My!

ADRs
TMRs
Probe Edits
NCLOS
Charge Denial Rates

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Additional Development Requests (ADRs)

- Initiated by Regional Home Health and Hospice Intermediary (RHHI) or Medicare Administrative Contractor (MAC).
- Can be pre payment or post payment.
- Are usually related to a ***probe edit*** being conducted by the RHHI/MAC.
- Primarily involve **technical** and **medical** reviews of hospice claims.

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Probe Edit

- Service-specific probes may include:
  - Non-cancer (long) length of stay (NCLOS); and,
  - General inpatient care.
- Provider specific.
- Beneficiary specific.
- Diagnosis driven.

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Technical Eligibility

- The following technical elements are required for hospice payment (and admission):
  - A valid and timely Notice of Election (NOE); and,
  - A valid and timely Certification of Terminal Illness (CTI).

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Challenges

- Maintaining "version control" of all printed forms to ensure that current and compliant forms are used by staff (NOE & CTI).
- Ensuring that clinical and billing departments communicate; or, there are sufficient checks and balances in place to prevent billing prior to obtaining written (signed) certifications.
- Obtaining and documenting oral certifications as needed.

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Technical Denials

- Technical claim denials occur when the hospice:
  - Fails (or chooses not) to respond to an ADR;
  - Submits the clinical record after the due date;
  - Fails to submit all requested documents;
  - Utilizes and submits invalid/incomplete forms; and,
  - Submits documentation that is untimely, inaccurate, or incomplete.

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Medical Denials

- A ***not medically necessary*** claim denial occurs when the hospice:
  - Submits documentation that does not clearly and consistently support hospice eligibility and limited prognosis (LCD not met);
  - Admits and/or recertifies non-terminal patients who require only custodial care (no decline); and,
  - Bills for a higher level of care than was **needed** by the patient and/or **provided** by the hospice.

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Medical Necessity "Test"

PROVIDER	ELIGIBILITY REQUIREMENTS
Hospital	DRGs.
SNF	Qualifying hospital stay & skilled need.
Home Health	Homebound status & skilled need.
Hospice	Terminal condition & limited prognosis (certification – life expectancy of 6 months or less ***if the disease runs its normal course***). Level of care – Needed ***and*** provided.

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Claim Denials

- Technical and medical denials are **not** mutually exclusive, for example:
  – A technical denial may occur at the ADR level and a medical may occur upon appeal.
- Technical denials are difficult to overturn.
- It is possible to request a "reopen" of the claim if a document was overlooked by the hospice or the reviewer.
- If payment is denied, the hospice may appeal the decision.

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The Medicare Appeals Process

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1st Level Of Appeal

PARTY HEARING APPEAL	FILING TIME FRAME	DECISION TIME FRAME	COMMENTS
Redetermination MAC / RHHI	120 days	60 days	This is a record review only; the hospice cannot discuss the patient with the reviewer.

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2nd Level Of Appeal

PARTY HEARING APPEAL	FILING TIME FRAME	DECISION TIME FRAME	COMMENTS
Reconsideration Qualified Independent Contractor (QIC)	180 days	60 days	Typically, this is the last opportunity to introduce additional supportive evidence of eligibility. This is a record review only; the hospice cannot discuss the patient with the reviewer.

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3rd Level Of Appeal

PARTY HEARING APPEAL	FILING TIME FRAME	DECISION TIME FRAME	COMMENTS
Administrative Law Judge (ALJ)	60 days	90 days	The ALJ hearing affords the hospice an opportunity to discuss the patient and review the details of the case (eligibility, care needs, etc.). Hearings are typically conducted via teleconference.

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4th Level Of Appeal

PARTY HEARING APPEAL	FILING TIME FRAME	DECISION TIME FRAME	COMMENTS
Medicare Appeals Council	60 days	90 days	Hospices should only appeal to the Medicare Appeals Council in cases where the ALJ has misapplied the law or misunderstood the facts of the case. This is typically not a formal hearing (record review only).

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5th Level Of Appeal

PARTY HEARING APPEAL	FILING TIME FRAME	DECISION TIME FRAME	COMMENTS
Federal District Court	60 days	N/A	Uncommon for hospices to appeal to this level.

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Charge Denial Rate (CDR)

- The CDR is expressed as a percentage; and,
- It is calculated by taking the ***total dollar amount*** of the charges denied, divided by the total dollar amount of the charges of all reviewed claims, multiplied by 100.
  - If a hospice had $2,000 in claim denials, and the total of the claims reviewed equaled $10,000, a 20% CDR would result ($2,000 ÷ $10,000 x 100).

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Targeted Medical Review

- CMS requires MACs/RHHIs to "target" medical review activities on providers or services that place Medicare funds at the greatest risk.
- Based on probe edit results (CDR >10-15%), the MAC/RHHI may place a provider on Targeted Medical Review (TMR).
- Once the CDR reaches an acceptable level for a quarter, TMR activities typically cease.

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Corrective Action Plan

- If a provider has a very high CDR, or an unacceptable CDR for several quarters, the MAC/RHHI may request a written Corrective Action Plan (CAP).
- A CAP outlines all actions the provider will take to correct the problems identified during the medical review process.
- The CAP is either accepted by the MAC/RHHI or sent back to the provider with suggested changes.

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Strategies for Managing ADR/ TMR Activity

Be pro-active!

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Strategies For Managing ADR/ TMR Activity

- Monitor the status of all claims on the Fiscal Intermediary Standard System (FISS) daily.
- Track all ADRs, claim denials, and appeals on a spreadsheet, including but no limited to:
  - Patient and diagnosis;
  - ADR notification date;
  - Submission due date;
  - Actual submission date;
  - Postal tracking number;
  - Appeals (level, dates, decisions, etc.); and,
  - Dollar amounts (held or in question, paid, and denied).

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Strategies, cont'd.

- Develop and maintain a good working relationship with the RHHI.
- If the hospice has a relatively small census, it can request a sample size reduction (from 40 to 20 claims).
- Continue billing.

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Strategies, cont'd.

Provide a cover letter – written by a hospice physician, nurse, or independent expert consultant – summarizing the patient's eligibility and limited prognosis, quoting from the clinical record whenever possible.
Pt fully & completely meets LCD guidelines.
Pt partially meets LCD guidelines with conditions.
Pt partially meets LCD guidelines without conditions.

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Strategies, cont'd.

- Include reference citations, research papers, statistics, and/or current medical or nursing articles that lend support to your case.
- If favorable, include statistics about your hospice (e.g., the number and percentage of patients in a given category.
  – For example: Only 2% of the hospice's patients had a diagnosis of dementia during the dates of service under review. (The national average for 2008 was 11.1%).

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Strategies, cont'd.

- Request an educational conference call with the RHHI/MAC to learn more about the ADR/TMR process, what the nurse reviewers are finding (or not finding) in your clinical records, suggestions for improvement, etc.
  – Note: This is **not** the time nor the place to debate findings, challenge claim denials, confront misinterpretation or misunderstanding of hospice regulations or LCD guidelines, etc.

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Strategies, cont'd.

- Consider appointing an in-house "ADR Coordinator" to oversee the ADR/TMR process.
- Do a root case analysis on all claim denials seeking to identify documentation related and other opportunities for improvement.
- If improvements are identified, initiate a performance improvement project and monitor progress toward goals.
- Require a joint visit by the hospice physician and RN for all patients with questionable eligibility.

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Strategies, cont'd.

- Provide or purchase education for all IDT member on the ***current*** LCD guidelines and how to document to support initial and ongoing hospice eligibility regardless of discipline.
- Carefully assess all patients using LCD-based worksheets at admission, each IDT meeting and recertification.
- Clearly document the physician's rationale for admitting and recertifying all patients.
- Address any lack of decline, stability, or improvement (disease trajectories, POC, etc.).

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Strategies, cont'd.

- When preparing the clinical record for submission:
  - Photocopy the requested documents (**never** submit original clinical records);
  - Highlight and flag sections of the clinical record that support the patient's hospice eligibility and limited prognosis, paying particular attention to LCD guideline requirements;
  - Include clinical record documentation from before and/ or after the dates of service under review, and any other supporting documentation, to strengthen your case;

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Strategies, cont'd.

- Review packet to ensure all requested and necessary documents are included;
- Number each page of documentation being submitted to ensure that no pages are unaccounted for, skipped, or lost;
- Keep an exact copy of the numbered packet until the final appeal decision has been rendered;
- If additional documentation is added to the packet on appeal to the QIC, continue on with the pagination; and,
- Submit each clinical record separately, using US Postal Service with tracking and return receipt request.

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Strategies, cont'd.

- If appealing:
  - Know the strengths and weaknesses of each case;
  - Highlight the strengths and anything that supports hospice eligibility and limited prognosis;
  - Highlight any weaknesses (e.g., if the patient does not fully and completely meet the LCD guidelines, emphasize the portions of the LCD that are met – and how – and include a summary of the physician's rationale for admitting or recertifying the patient; and,
  - Discharge ineligible patients, if any (consider not appealing these claims).

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Strategies, cont'd.

- At the Administrative Law Judge (ALJ) level of appeal:
  - Hospices may choose a telephone appeal or a video teleconference;
  - Request a copy of the case file and review every page prior to the hearing;
  - Ensure that all submitted documents are present;

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Strategies, cont'd.

- Assemble a team to assist with the hearing, including the hospice physician and RN case manager from your hospice;

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Strategies, cont'd.

- Organize all information prior to the hearing;
- Prepare the team to present the best possible case and speak to the patient's eligibility;
- Keep in mind that judges typically do not know hospice regulations or LCD guidelines;
- The judge may have a medical expert available to objectively answer any clinically-oriented questions that arise during the hearing (the expert is not likely to know the LCDs or the regulations either);

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Strategies, cont'd.

- Although the QIC is the last official opportunity to submit additional supportive documentation, the ALJ may allow new evidence if the hospice has a compelling reason for requesting its submission and consideration; and,
  - Note: If the new evidence is not allowed, the hospice is not precluded from discussing or referring to the information during the hearing.

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Strategies, cont'd.

- Respectfully provide education to the judge during the hearing, focusing particular attention on:
  - **Medicare** eligibility requirements for hospice;
  - "Failure to die" ≠ "ineligibility";
  - A terminal disease trajectory implies but does not necessarily require decline;
  - The "bell-shaped curve" of hospice's length of stay (use your program's actual data if favorable); and,
  - The patient and family are the "unit of care" and care is required to be interdisciplinary and palliative in nature.

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Strategies, cont'd.

- Know when to seek legal and/or clinical consultation to:
  - Assist with managing ADR/TMR activities;
  - Provide legal advocacy;
  - Review clinical records to assess the type and quality of IDG documentation;
  - Provide independent expert options regarding patient eligibility;
  - Identify documentation related opportunities for improvement;
  - Provide staff training; and,
  - Provide support and coaching throughout the appeal process.

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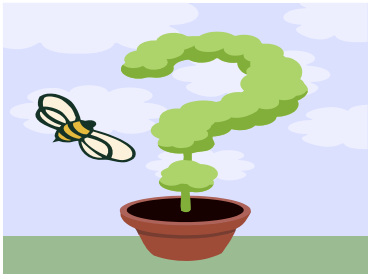
QUESTIONS



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THANK YOU!

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Hospice Education Network, Inc.

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