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Responding to a Home Health & Hospice Targeted Probe & Educate Additional Documentation Request 12/14/2022

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Today's Presenters

National Government Services Provider Outreach & Education Home Health & Hospice Team

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Objectives

- Provide information regarding Targeted Probe and Educate, as well as how to respond to an ADR
- Offer information regarding current TPE edits in each jurisdiction, the importance of documentation collaboration, as well as submission of medical record documentation upon request from the MAC

Agenda

- ADR
- Targeted Probe & Educate
- Preparing ADR Documentation
- Submission of Medical Record Documentation
- References & Resources
- Question & Answer Period

Additional Documentation Request

ADR

- An ADR is a request for documentation to support a Medicare claim
  - It is imperative that providers maintain a process or policy that ensures requested medical record documentation is collected efficiently and appropriately for review
  - Methods or techniques often utilized to ensure proper documentation is collected include
    - Mock Chart
    - Check List
    - Staff Members Assigned to Collect Documentation
    - Staff Members Assigned to Review Documentation Prior to Submission

ADR

System Issues ADR	• Claim suspends to status/location SB 6001 • ADR is sent to provider • Provider has **45 days** to return records to the MAC
Records are NOT received by day 45	• On day 46 the system will deny the claim and move it to S/L DB 9997 • Claim assigned reason code 56900
Wait one week and recheck status/location	• If the records were received the claim will move to S/L SM 5REC • If denial code appears, recheck, call the PCC for assistance, if necessary

ADR

- Incorporating the methods and techniques mentioned into policies/procedures will assist in ensuring
  - Appropriate documentation is obtained from outside entities
  - Records are reviewed for accuracy by multiple people prior to submission
  - All eligibility criteria have been met
  - All proper documentation is included in the medical record prior to submission
  - Proper claims payment

ADR

- Utilize instructional information on the ADR to assist in creation of the checklist or mock chart

THIS CLAIM REQUIRES ADDITIONAL INFORMATION IN ORDER TO MAKE APPROPRIATE PAYMENT DETERMINATION AND PROCESSING. PROVIDED BELOW ARE RECOMMENDED SUPPORTING DOCUMENTS, BUT NOT AN ALL INCLUSIVE LIST. THE DOCUMENTATION SHOULD SUPPORT THE VERIFICATION OF THE ISSUE THAT GENERATED THIS REQUEST. FOR FURTHER INFORMATION, ENTER THE REASON CODE(S) LISTED BELOW IN THE APPROPRIATE FIELDS IN THE ON-LINE SYSTEM. WE ACCEPT DOCUMENTS VIA PAPER, FAX, CD/DVD AND ESMD OMB #0938-0969

PLEASE NOTE:

MEDICAL RECORDS ARE DUE TO THE MAC WITHIN 45 CALENDAR DAYS.

NON-MEDICAL RECORDS ARE DUE TO THE MAC WITHIN 14 CALENDAR DAYS.

ADR

- The ADR provides helpful hints to help appropriate claims payment

MEDICARE REQUIRES A LEGIBLE IDENTIFIER FOR SERVICES PROVIDED AND ORDERED.

MEDICARE WILL ACCEPT CLEARLY LEGIBLE HANDWRITTEN SIGNATURES, HANDWRITTEN INITIALS OR ELECTRONIC SIGNATURES. STAMPED SIGNATURES ARE NOT ACCEPTABLE ON ANY MEDICAL RECORD.

ADR

PATIENT IDENTIFICATION, DATE OF SERVICE, AND PROVIDER OF THE SERVICE SHOULD BE CLEARLY IDENTIFIED ON THE SUBMITTED DOCUMENTATION. IF THE RENDERING PROVIDER SIGNATURE IS NOT CLEARLY LEGIBLE, ATTACH A SIGNATURE LOG/KEY THAT INCLUDES THE TYPED NAME OF THE PROVIDER WITH CREDENTIALS, THE SIGNATURE, AND THE INITIALS FOR EACH PROVIDER FOR WHICH THE RECORDS ARE REQUESTED. IF YOU QUESTION THE LEGIBILITY OF YOUR SIGNATURE, YOU SHOULD SUBMIT AN ATTESTATION STATEMENT IN YOUR DOCUMENTATION RESPONSE. IF THE SIGNATURE REQUIREMENTS ARE NOT MET, THE REVIEWER WILL CONDUCT THE REVIEW WITHOUT CONSIDERING THE DOCUMENTATION WITH THE MISSING OR ILLEGIBLE SIGNATURE. THIS COULD LEAD THE REVIEWER TO DETERMINE THAT THE MEDICAL NECESSITY FOR THE SERVICE BILLED HAS NOT BEEN SUBSTANTIATED.

PLEASE SUBMIT THE SUPPORTING DOCUMENTATION WITHIN 45 DAYS FROM THE DATE OF THIS NOTICE. THIS DOCUMENTATION MUST BE CLEAR AND LEGIBLE.

Date

Signature

Legibility

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ADR

- The ADR does not provide an all-inclusive list of what should/should not be included for medical record submission
  - **Reminder:** It is important to review the records prior to submission to ensure documentation supports eligibility criteria

Targeted Probe & Educate

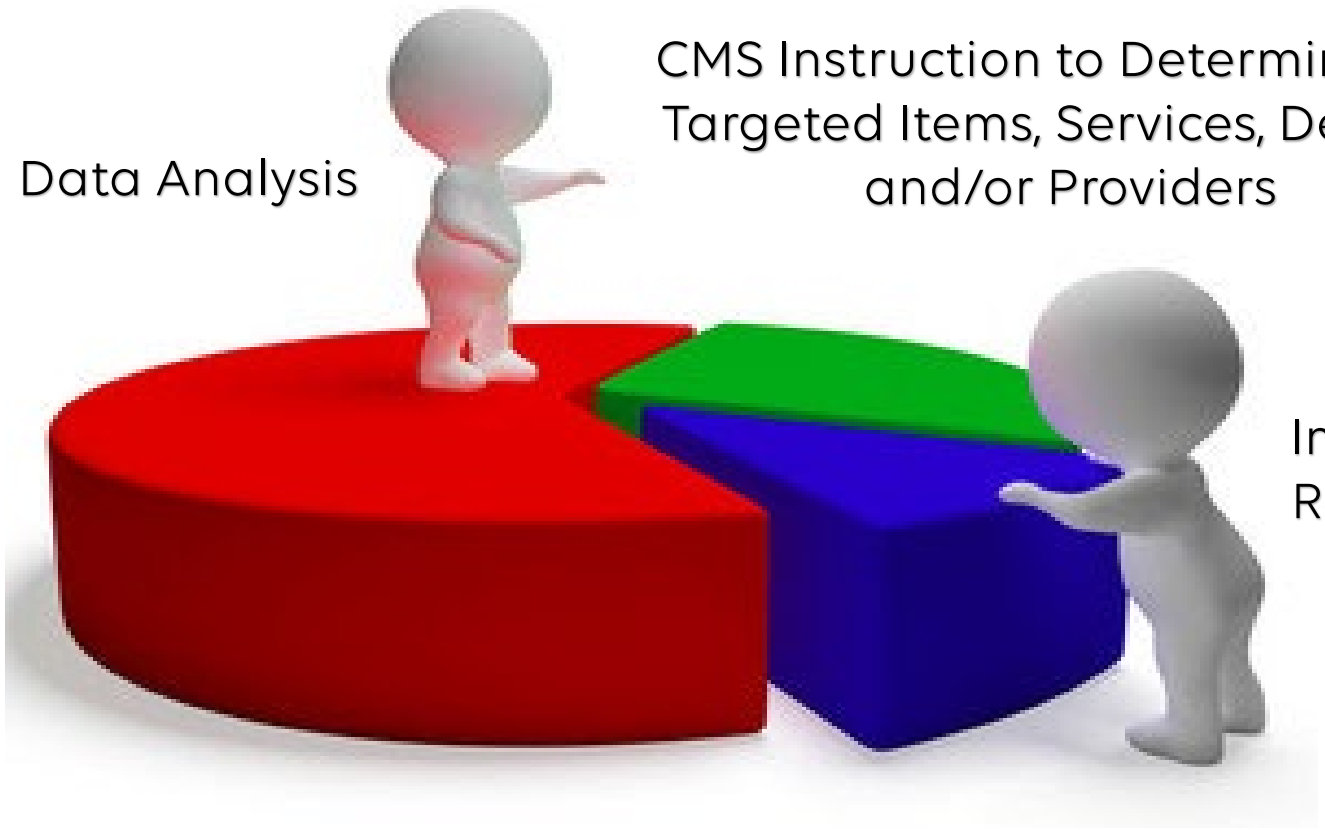
TPE

- CMS's TPE program is designed to help providers and suppliers reduce claim denials and appeals
- The goal is to help providers quickly identify and improve errors

TPE

Data Analysis

CMS Instruction to Determine the Targeted Items, Services, Devices and/or Providers

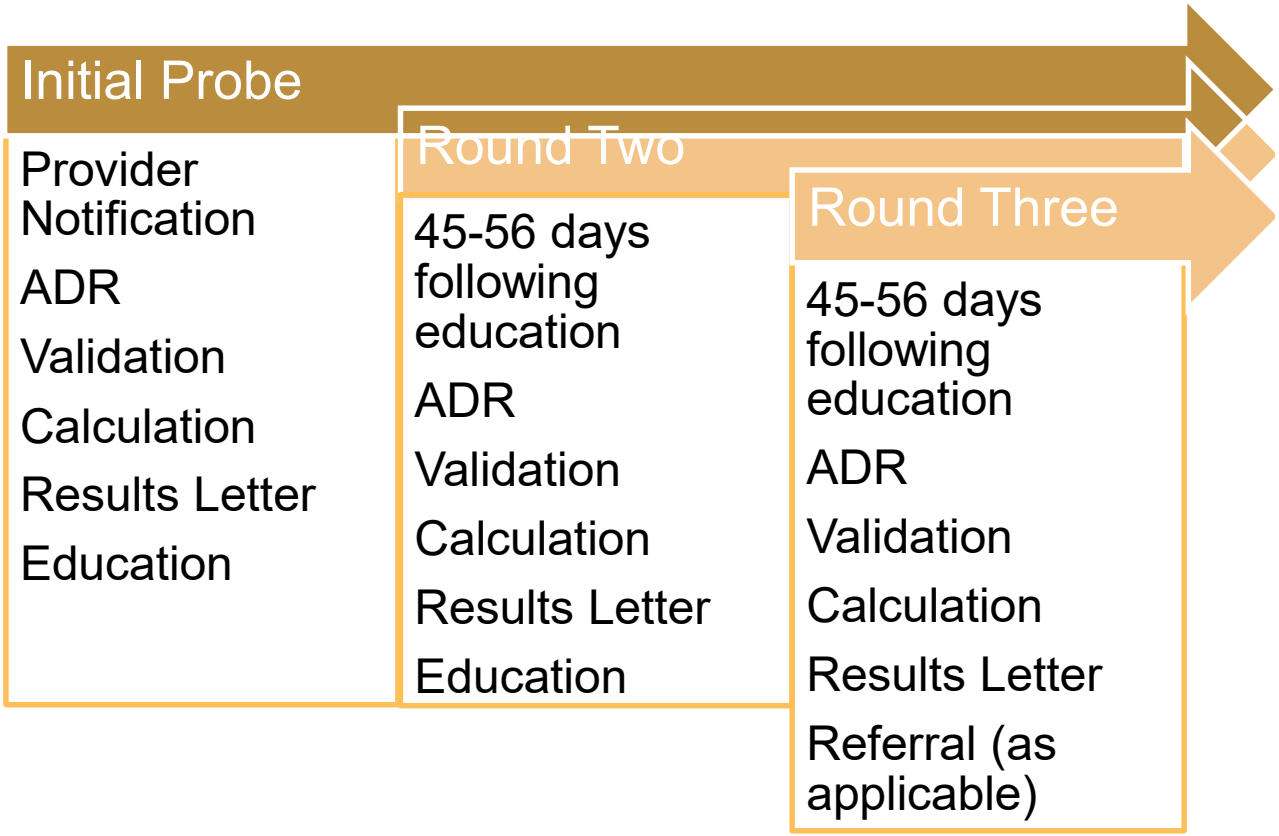


Improper Payment Reduction Strategy

TPE


Utilization Patterns
Trends
Billing Comparisons
Data Analysis

TPE



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Additional Rounds of TPE
Referral for Revocation
Corrective Action
Extrapolation
Referral to UPIC
Referral to RA
100% Pre-Pay Review

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TPE

- CMS's TPE program is designed to help providers and suppliers reduce claim denials and appeals through one-on-one help.

  The goal: to help you quickly improve. MACs work with you, in person, to identify errors and help you correct them. Many common errors are simple – such as a missing physician's signature – and are easily corrected.

- TPE reviews can be either prepayment or postpayment and involve MACs focusing on specific providers/suppliers that bill a particular item or service.

TPE

- Notice of review includes reason for review
- Request 20 – 40 claims
- Do not send documentation until ADR received for each claim
- ADRs generated via the usual process
- 45 days to respond
- Non-responders could be referred to the RA or UPIC
- Records Reviewed within 30 days of receipt
- Results letter offers 1:1 education

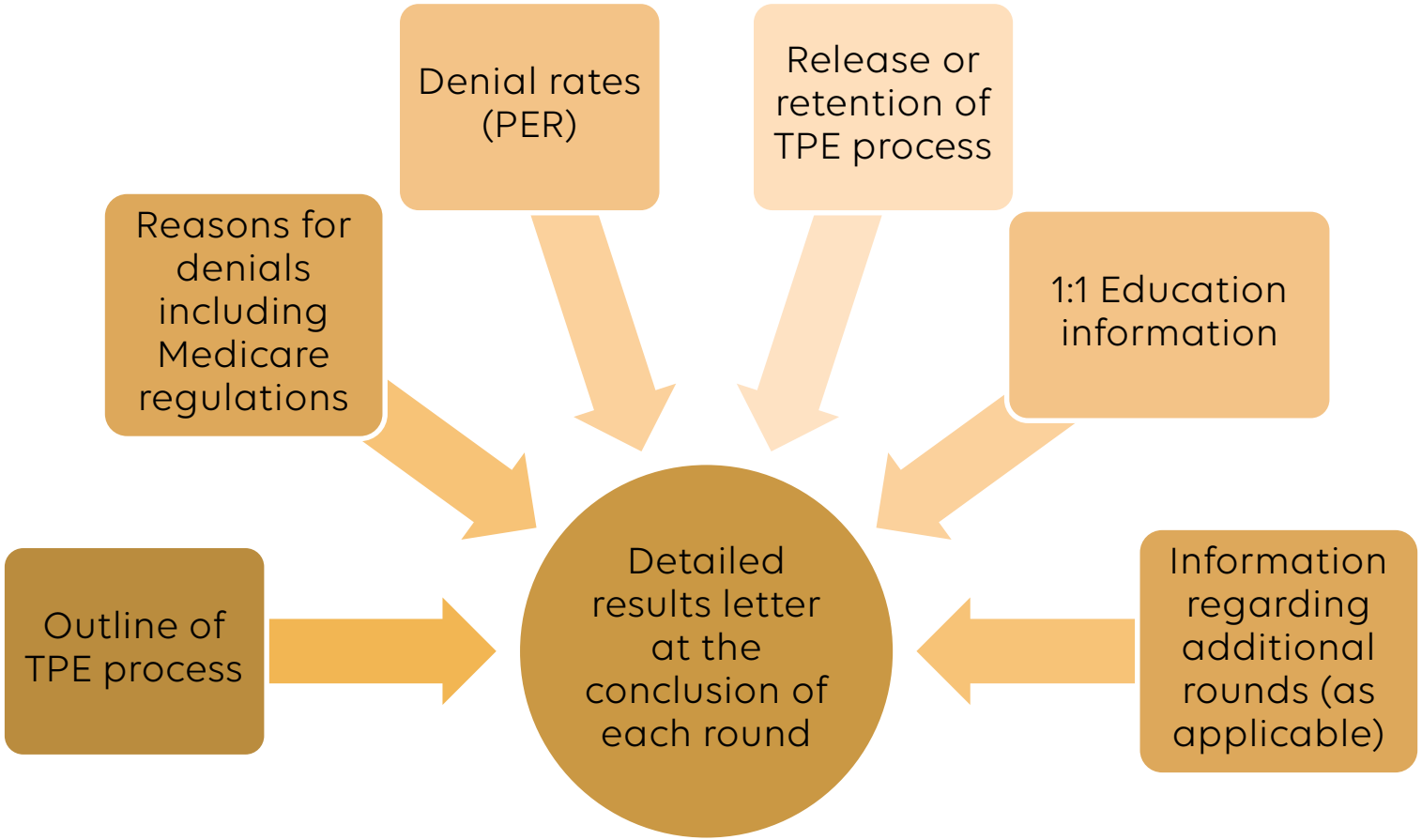
TPE

- Additional Rounds of Review
  - Payment error >15%
  - Additional rounds include education with Medical Review staff following each round of review
  - Payment Error Rate
    - Payment/Payment Denied
    - 1,000/500 = 50% PER
  - Claims Error Rate
    - # of Claims/Claim in Error
    - 10 Claims/5 Claims Denied = 50% CER

TPE

- Medical Review of Records for:
- Technical Components
  - Physician certification
  - Physician orders
  - Beneficiary election statement
- Eligibility Requirements
  - Medicare coverage guidelines
  - Medical necessity
  - Documentation to support services billed

TPE


Denial rates (PER)
Release or retention of TPE process
Reasons for denials including Medicare regulations
1:1 Education information
Outline of TPE process
Detailed results letter at the conclusion of each round
Information regarding additional rounds (as applicable)

Submission of Medical Record Documentation

Submission of Medical Record Documentation

- Documentation Collaboration
- Sources of documentation that may assist in supporting eligibility criteria include
  - Discharge summary
  - Progress notes
  - History and physical
  - Plan of care
  - Case Management records
  - Discharge Planning documentation
  - Therapy records
  - Face-to-face encounter documentation

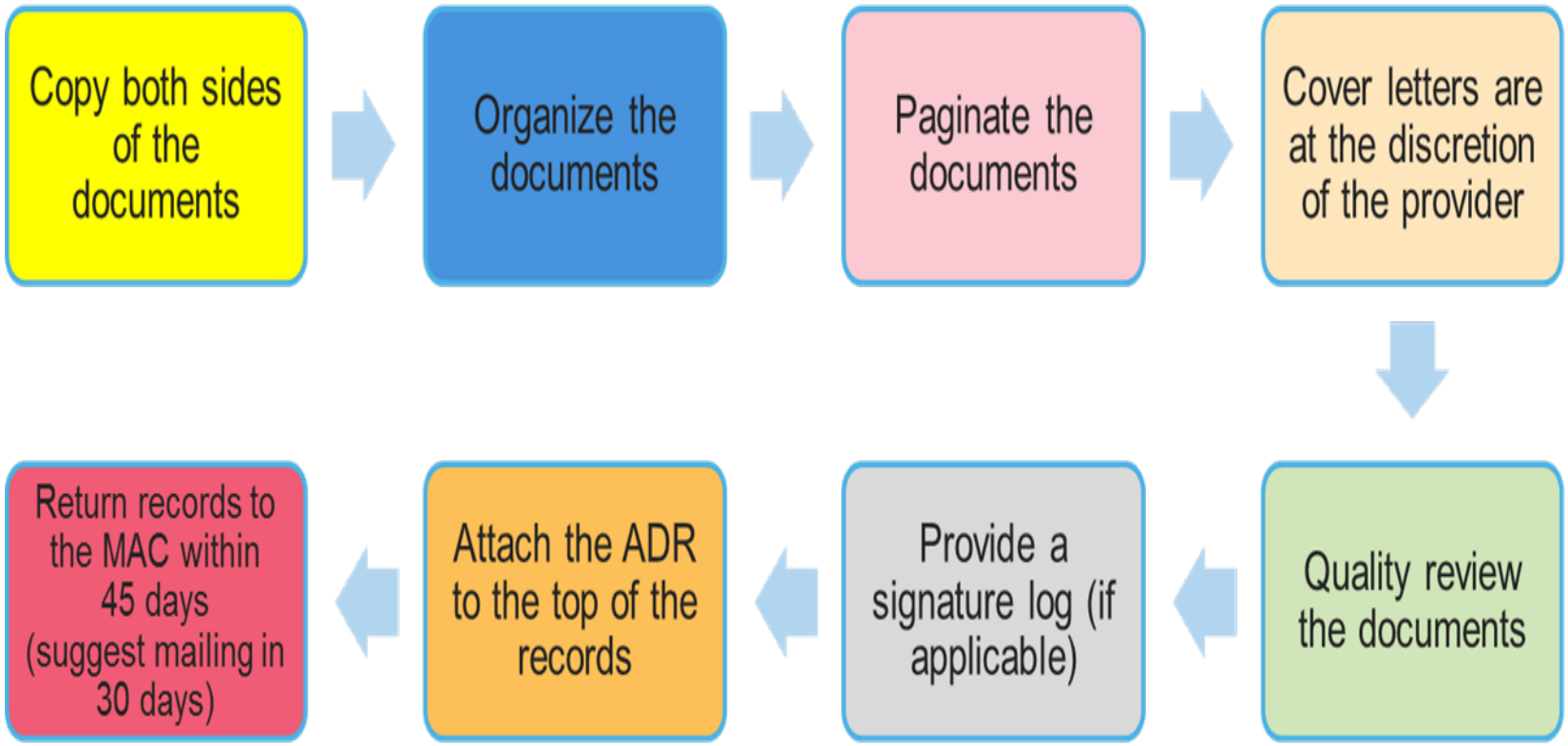
Submission of Medical Record Documentation

- Documentation Preparation
- Prior to submission of documentation, it is imperative that all medical record documentation is completely reviewed to ensure
  - All pages are for the appropriate patient
  - PECOS – Validation for all physicians involved in the patient's care for all DOS in the period of care
  - Appropriate OASIS submission
  - Any and all therapy evaluations and reevaluations are included
  - The patient's name is on each page (front and back where appropriate)
  - The correct dates of service for the claimed period of care
  - Dates and signatures are clear and appropriate
  - Legibility of all handwritten documentation

Submission of Medical Record Documentation

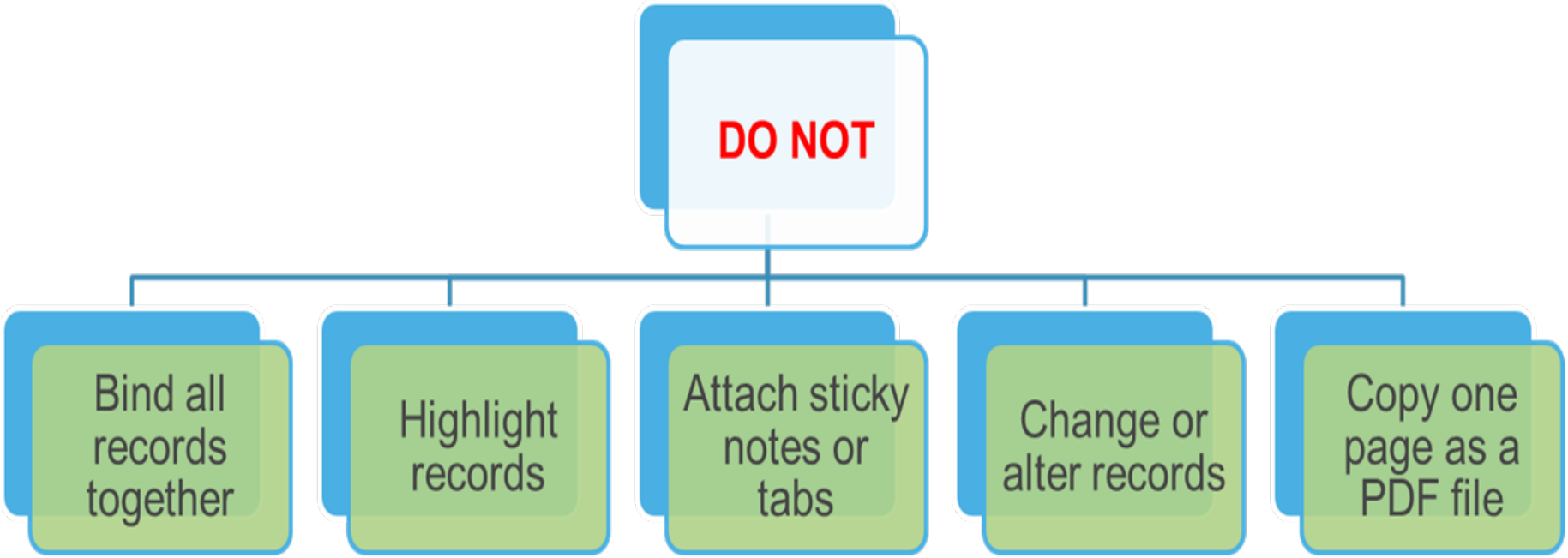
- Documentation Preparation
- Prior to submission of documentation, review all records to ensure
  - Identifiable credentials for each clinician signature
    - Signature sheets as appropriate from agency and referring facility/office
  - Accuracy of documentation
  - All staples, paperclips, binder clips, sticky notes, rubber bands, etc. are removed prior to submission
  - Pages are not folded over, cut off or crinkled during copying/printing/faxing
  - Highlighter is not utilized
  - ADR is placed on the top of the medical record
  - Reminder: Black ink copies best
  - Provider contact name and telephone number

Submission of Medical Record Documentation



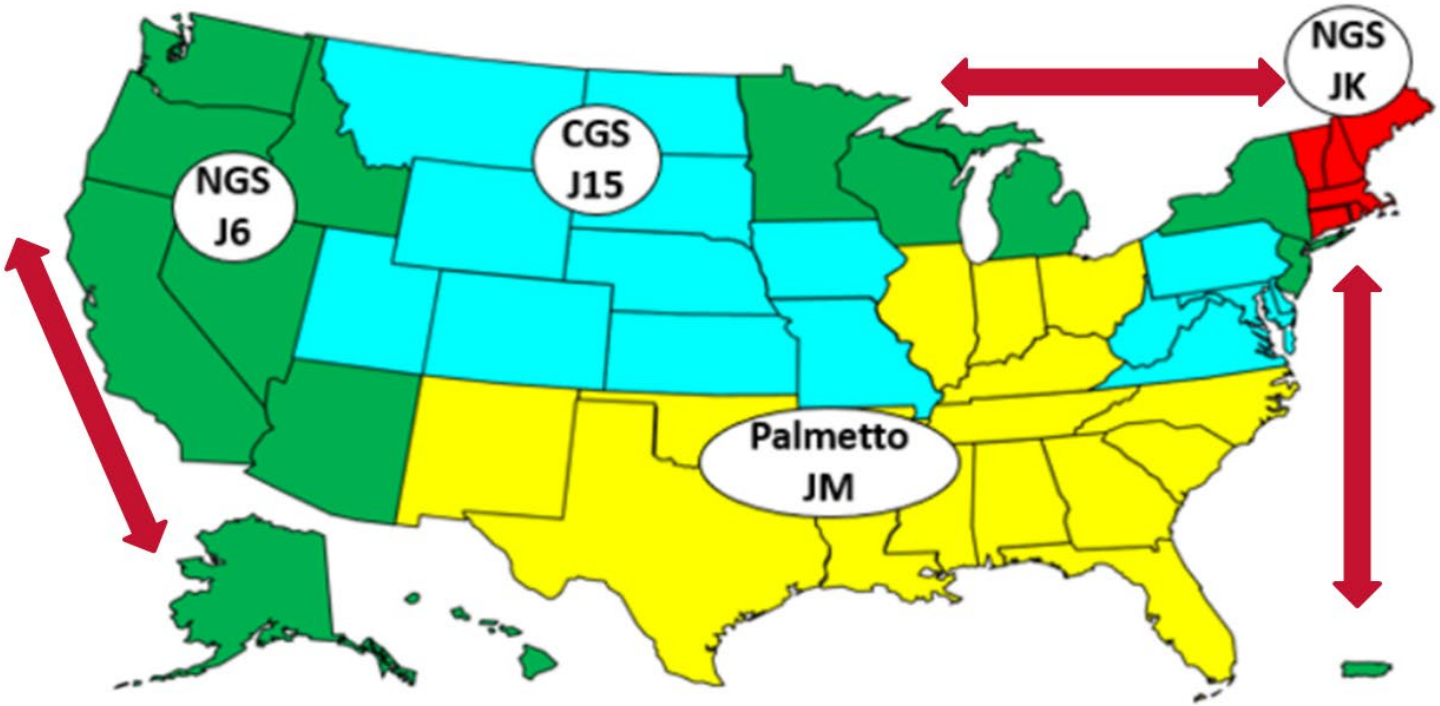
Submission of Medical Record Documentation

Documentation Preparation



Submission of Medical Record Documentation

Home Health & Hospice Jurisdictions



Submission of Medical Record Documentation **J6**

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Submission of Medical Record Documentation **JK**

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Indianapolis, IN 46207-7108

FAX: 315.442.4390

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56900 Denials

Records Not Received

Home Health & Hospice References & Resources

CMS Home Health Resources

- CMS IOM Publication 100-02, *Medicare Benefit Policy Manual,* Chapter 7
- CMS IOM Publication 100-04, *Medicare Claims Processing Manual,* Chapter 10
- CMS IOM Publication 100-08, *Medicare Program Integrity Manual,* Chapter 6
- Medicare & Medicaid Program: Conditions of Participation for Home Health Agencies

CMS Hospice Resources

- *Medicare Contractor Beneficiary and Provider Communications Manual*
- CMS IOM Publication 100.02, *Medicare Benefit Policy Manual,* Chapter 9, Coverage of Hospice Services Under Hospital Insurance
- CMS IOM Publication 100-04, *Medicare Claims Processing Manual,* Chapter 11, Processing Hospice Claims
- Hospice Code of Federal Regulations
- Model Hospice Election Statement Example
- Model Hospice Election Statement Addendum Example

CMS Home Health & Hospice Resources

- HH PPS web page
- Home Health Agency (HHA) Center
- MLN® Publication, "Home Health Prospective Payment System"
- Hospice Center Webpage
- Hospice Code of Federal Regulations
- The Medicare Learning Network®

MAC Contact Information

National Government Services
Jurisdiction 6

- Website
- IVR Unit – 877-277-7287
- Provider Contact Center – 866-590-6724
- LCDs and Policy Articles – See website, Medical Policy & Review Tab, Medical Policy Center

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Jurisdiction K

- Website
- IVR Unit – 866-275-7396
- Provider Contact Center – 866-289-0423
- LCDs and Policy Articles – See website, Medical Policy & Review Tab, Medical Policy Center

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Medicare University Credits

Medicare University Self-Reporting Instructions

- Log on to the National Government Services Medicare University site
  - Course Topic/Title =
  - **Session Title:** Responding to a HHH TPE ADR
  - Medicare University Credits (MUCs) = 1
  - Catalog Number =
  - Participant Code =
  - For step-by-step instructions on self-reporting please visit the Get Credit for Completed Courses on the NGS website

www.MedicareUniversity.com

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Thank You!

Any Questions?