

TLA's: Avoiding Pitfalls in the Land of Denials

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Presenter

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Disclosures

- No off-label discussions
- No other disclosures

Objectives

- Describe the Additional Development Request process of the CMS hospice fiscal intermediaries
- Discuss the fiscal intermediaries' hospice local coverage determinations
- Describe some strategies for preventing payment denials, writing appeals and presenting before the administrative law judge

What is a TLA?

- Tall Latte with Amaretto
- Teller, Alaska (airport code)
- Trial Lawyers Association
- The Lawrence Arms (band)
- Three Letter Abbreviation (acronym)

What the heck is a TLA?

Three Letter Abbreviation

Professionals seem to be in love with them

“Your father was brought by EMS for LOC. It appeared he was having a TIA with a negative MRI. We started TPA, but unfortunately he had a hemorrhagic CVA and was put into ICU. We’ve done an EEG and he appears to have PVS. We need to talk about DNR.”

This process is full of them!

What process?

- The process of paying for hospice care
- 85% of hospice care in the U.S. is provided to Medicare beneficiaries
- CMS pays for hospice care of Medicare beneficiaries who have a life expectancy of six months or less, if the disease runs its normal course
- CMS doesn't directly pay hospice providers

What is an FI?

- Two Letter Abbreviation
- Fiscal Intermediary
- Finland
- Fuel Injected
- Fecal Incontinence

What is an FI?

- So-called Fiscal Intermediaries
- Current proper term
 - *Regional Home Health Intermediaries*
 - About to change again to *MAC*
- Entities contracting with CMS to administer Medicare beneficiaries' benefits

Responsibilities of an FI

- Interpret Medicare guidelines
- Provide hospice education and training regarding the regulations
- Manage payment to providers for hospice services
- Monitor the eligibility of beneficiaries
- Conduct audits, including probe edits

How many current FI's are there?

- Three
- Four
- Thirty-seven
- Fifty

CMS “Regional Home Health Intermediaries” (RHHI’s)

- Cahaba GBA
 - CO, DE, D.C., IA, KS, MD, MO, MT, NE, ND, PA, SD, UT, VA, WV, WY
- National Government Services, Inc.
 - AK, AZ, CA, CT, HI, ID, ME, MA, MI, MN, NV, NH, NJ, NY, OR, RI, VT, WA, WI
- Palmetto GBA
 - AL, AR, FL, GA, IL, IN, KY, LA, MS, NM, NC, OH, OK, SC, TN, TX
- Most of today’s talk is based on Palmetto

What's a PCA?

- Progressive Corrective Action process
- Means by which FI's ensure that payments are being made in a manner consistent with Federal law and regulation
- Probe Edit
 - A large scale audit performed by an FI guided by a specific focus

More about Probe Edits

- Most common is NCLOS
 - Focus is on Non-Cancer Length of Stays
 - NCLOS rate is the ratio of patients whose LOS is > 210 days
 - If no patients > 210 days – NCLOS = 0
 - If 50% of patients > 210 days – NCLOS = 0.5
 - If all patients > 210 days – NCLOS = 1
 - NCLOS probe edit if NCLOS rate ≥ 0.2
- Other Probe Edits
 - Beneficiary specific
 - At request of others (e.g. OIG LTC edit)

NCLOS Teaching Point

- Palmetto tracks NCLOS by *beneficiary*
- Example:
 - If your hospice readmits a patient who was previously on hospice (yours or another hospice) for 180 days, that patient will count against NCLOS in just 30 days
- Other FI's apparently do not

What is an ADR?

- Adverse Drug Reaction
- Average Daily Rate
- Additional Development Request
- Alternate Dispute Resolution
- Additional Documentation Review

What's an ADR?

- Additional Development Request
- A request for medical records for an identified billing claim chosen for medical review
 - Part of a Probe Edit and PCA process
 - Dates are determined by the claim submitted by the hospice
 - Chosen at random among *all* non-cancer patients (not just LOS > 210 days)
- Payment is withheld for this beneficiary

ADR notifications

- FI issues an ADR
 - Discover in online posting
 - Receive letter
- Thirty (30) days to send in records
 - All records corresponding to care within the audited time-frame
 - All records indicating proper election of benefit and certifications
 - Any other records that support eligibility (including newly generated records)

What happens if no response

- If FI receives no response within 30 days
 - Payment for that claim is denied
 - Likely will trigger beneficiary specific ADRs for periods before (and after) this claim
 - May try to appeal for longer time (no guarantees)
- If repeatedly history of no response
 - FI will report to CMS
 - CMS may suspend that provider's Medicare status

Tips for handling new ADRs

- Have a reliable process for discovery
- Have a process for gathering & submitting information
 - Strongly consider review of information prior to submission
 - Highlight key points
 - May wish medical director involvement, including MD written narrative summary justifying care provided and hospice eligibility

What does the FI do with the ADR?

- Upon review, may approve claim
 - Billing hold is removed
- Upon review, may deny claim
 - Partial / Complete
- Technical denial– problems invalidating the claim
 - e.g. no valid EOB signature or no certification
 - Appeals **are** possible
- Medical denial based on ineligibility
 - Based on chart review/comparison with LCD

What is an LCD?

- Local Coverage Determination
- A set of criteria written by the RHHI to provide guidance regarding who is considered to meet CMS requirements for coverage
- There are multiple LCDs for multiple issues
- We're addressing *hospice* LCDs today

Why aren't there NCD's?

- National Coverage Determinations
- There are – but not for hospice
- NCDs are administered differently
 - Typically limited or no appeal
 - Usually used only if clear delineations
 - Example – qualifying for Medicare Dialysis Benefit
- LCDs allow greater flexibility
 - i.e. “they are better than the alternative”

Do the RHHI's use the same LCDs?

- Cahaba GBA
 - 1 hospice LCD with 9 diagnoses available at <http://tinyurl.com/2r4e3k>
- National Government Services, Inc
 - 1 hospice LCD with 9 diagnoses available at <http://tinyurl.com/2smg4u>
- Palmetto GBA
 - 9 hospice LCDs available at <http://tinyurl.com/2pl688>
- All are now very similar
- Constantly evolving with updates

More on LCDs and ADRs

- All have statements that basically say that there are patients who are eligible, but do not meet the LCD – these are considered individually
- Palmetto apparently uses nurse reviewers at the first level of consideration
- Denials typically are short one or two sentence statements

Are LCDs based on ICF?

- International Classification of Function
- Designed as an adjunct to ICD-10
 - ICD-9 is still the standard in the US
 - Much of the developed world has switched
- Palmetto is a proponent of ICF

BUT

- ICF is not a required part of the LCDs or hospice's eligibility documentation

Teaching Points on Eligibility

- Know your FI's LCDs!
- Have documentation in the chart that is consistent with the applicable LCD
 - Example – If the diagnosis is Adult Failure to Thrive, then there should be Karnofsky or Palliative Performance Scale data and Body Mass Index information on the chart!
- If the patient does not meet an LCD, have documentation and explanatory statements backing up why the patient is terminal
- “Patient is hospice eligible” is not adequate!

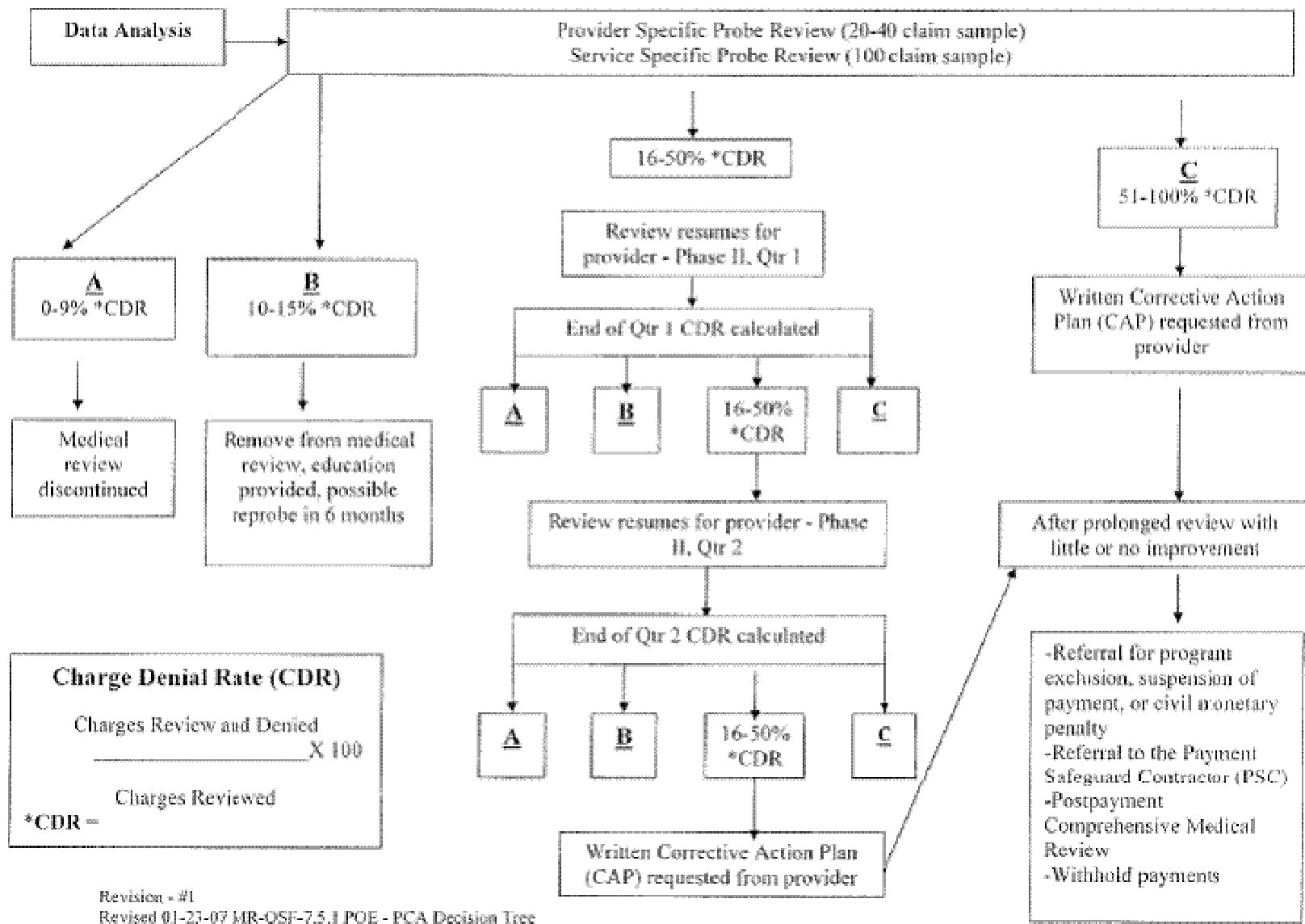
ADR is denied – now what?

- Accept the denial and do nothing
 - No payment will be forthcoming
 - Expect more ADRs on that patient
- Appeal (within 60 days of denial notice)
 - First level asks FI for a “Redetermination”
 - Done by a panel (nurse + doctor?)
 - Requested by letter (more to follow)
- Whatever you do
 - FI calculates your CDR

What is a CDR?

- Charge Denial Rate for a quarter
- A calculation of the dollar amounts denied divided by the total dollar amounts reviewed
- If CDR is
 - < 15% - taken off Probe Edit
 - 10-15% - may open Probe Edit after six months
 - > 15% - Probe Edit continues another quarter with even more charts pulled (up to 25%)
 - > 15% in 2nd Quarter – continues + possible request for a Corrective Action Plan
 - > 50% - moves directly to CAP

PCA Decision Tree



Charge Denial Rate (CDR)

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

Revision - #1
Revised 01-23-07 MR-QSF-7.5.1 POE - PCA Decision Tree

What % of Palmetto providers moved to 2nd Q review (1st Q 2008)?

- 10%
- 25%
- 35%
- 60%

The realities of this

- Palmetto Coalition – latest report
- 252 providers identified for review
- 153 providers moved to 2nd quarter
- 32 providers moved to CAP
 - Corrective Action Plan

Redetermination outcomes

- Agree with you and overturn the denial
 - Claim is paid
 - Billing hold is removed
 - Charges credited to current quarter's CDR
- Uphold the denial by letter
 - Provides narrative explanation of the denial
 - Explanation of how to appeal

Redetermination is denied – now what?

- Accept the denial and do nothing
 - No payment will be forthcoming
 - Expect more ADRs for this patient
- Appeal (within 60 days of denial notice)
 - Second level asks QIC for a “Reconsideration”
 - Done by letter *to the QIC* explaining why you disagree with the decision
 - Last opportunity to add more information (without special circumstances)

What's a QIC?

- Quality Inspection Center
- Quick Implementation Control
- Qualified Independent Contractor
- Quality Information Checklist
- Quarter Inch Cartridge

What's a QIC?

- Qualified Independent Contractor
 - An independent agency contracted by CMS to review appeals
 - Review is done by a physician working for the QIC
- Is completely outside of the FI's influence
 - Other than being paid by the FI to do the review

What do you put in a letter?

- Redetermination/Reconsideration letters
- Explicitly state what you are asking for
- Explicitly state that you disagree with the decision to deny payment
- Explain how this patient is eligible
 - Must be backed up by the record
- If adding new information, make sure to include that with the letter
 - Including narrative summaries, new physician visits, new diagnostic tests, phone conversations, etc.

More on letter-writing

- If meets an LCD – explain how
- If doesn't meet an LCD – don't try to fudge
 - Just explain why the patient is eligible anyway
- Keep it short and to the point
- It's fine to use a template from old letters
 - But don't make it obvious
- Be on time
 - If you miss the deadline, it is denied
- Be honest
 - If the patient isn't eligible, don't appeal
- If the patient has died – SAY SO!

Reconsideration outcomes

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What's an ALJ?

- Administrative Law Judge
 - Category of Federal judges
 - Specially trained to handle regulatory appeals, such as Medicare cases
- May or may not be familiar with hospice
 - But many have learned during this Probe Edit
- Legal hearing
 - Sworn testimony (i.e. criminal penalties for perjury)

ALJ Appeals

- Must request hearing in writing
 - Within time-frame specified by the QIC denial
- ALJ determines whether to hear or not
 - Will admit new information only if extenuating circumstances
- Hearing is on the merits of the case
 - Like starting from the beginning of the process

VC or TC?

- All hearings now held by
 - Videoconference
 - Teleconference
- Determination made by the ALJ
 - Typically, bigger cases (\$\$\$) more likely to involve VC
- Right to legal counsel (both sides)
 - Usually not present unless \$\$\$\$\$
- May combine multiple cases into one hearing

Proceedings

- ALJ initiates the call
- Explains the process
- Swears in witnesses
- From that point on – anything can happen
 - Wide variability among judges
- (Feels a lot like People's Court)
- *May* give indication of decision
- Will give final decision in writing

ALJ outcomes

- Agree with you and overturn the denial
 - Claim is paid
 - Billing hold is removed
 - Charges credited to current quarter's CDR
 - Don't expect this to happen quickly
- Uphold the denial by written opinion
 - Provides narrative explanation of the case including the rationale for the decision
 - You can still appeal – regular court system

Redetermination Cases

Decision	Total	Percent
Affirmed	727	54%
Dismissed	89	7%
Reversed (Partial or Complete)	524	39%

Palmetto GBA data – First Quarter 2008

Reconsideration Cases

Decision	Total	Percent
Affirmed	224	82%
Dismissed	11	4%
Reversed (Partial or Complete)	39	14%

Palmetto GBA data – First Quarter 2008

ALJ Cases

Decision	Total	Percent
Affirmed	26	32%
Dismissed	8	10%
Reversed (Partial or Complete)	48	59%

Palmetto GBA data – First Quarter 2008

Putting it all together

- Know the process
- Don't miss the deadlines
- If you believe your patient is eligible
 - Follow the process and fight for them
- If you decide your patient is not eligible
 - Work on fixing the internal processes for eligibility reassessment
- Designate a local expert
 - Or hire an outside consultant
- Be willing to ask for help

Wrap-up!

Questions & Answers