TIPS FOR DEALING WITH ADRs, PROBE EDITS, AND THE MEDICARE APPEALS PROCESS

Key Points:

- The Centers for Medicare & Medicaid Services ("CMS") and its contractors have broad ability to perform pre-payment and post-payment medical reviews of hospice claims. Hospices most commonly find themselves dealing with pre-payment medical reviews through the Additional Document Request or Additional Development Request ("ADR") process initiated by their Fiscal Intermediary ("FI") or Medicare Administrative Contractor ("MAC").

- Typically, these ADRs relate to a particular probe or edit conducted by the Intermediary. The probe or edit may be service-specific (e.g. non-cancer length of stay, general inpatient care, etc.), provider-specific, beneficiary-specific or diagnosis driven.

- If claim payment is denied by the Intermediary after its ADR review (initial review determination), the hospice may choose to appeal that denial through the Medicare appeals process. The steps in the appeals process are:
  - **Redetermination** (reviewed by the Fiscal Intermediary)
    - Time Frames:
      - The appeal is due within 120 days of receipt of denial.
      - The Intermediary must issue a decision within 60 days of receiving the appeal.
    - Details about this level of review:
      - This is only a paper review. There is no opportunity to discuss the case with the decision-maker. While it is a step in the process, hospices may not receive a payment reversal at this level of review.
  - **Reconsideration** (reviewed by a Qualified Independent Contractor ("QIC"))
    - Time Frames:
      - The appeal is due within 180 days of receipt of redetermination decision.
This is the last appeal step that “new” evidence can automatically be included as part of the review request.

The QIC must generally issue a decision within 60 days of receiving the appeal.

All written evidence must be submitted at this level.

- **Details about this level of review:**

  - This is only a paper review. There is no opportunity to discuss the case with the decision-maker. While it is a step in the process, hospices may not receive a payment reversal at this level of review.

  - **Administrative Law Judge (“ALJ”)**

    - **Time Frames:**

      - The appeal is due within 60 days of receipt of reconsideration decision.

      - The ALJ must generally issue a decision within 90 days of receiving a hearing request.

    - **Details about this level of review:**

      - This is the first opportunity to have a discussion with a decision-maker about the case.

      - The Office of Medicare Hearings and Appeals (OMHA) will schedule a telephone appeal. Hospices may choose a telephone appeal or a video teleconference (VTC). Success may be more likely if the ALJ can see the advocates for the hospice program. The ALJ Request Form does not contain a checkbox for a VTC request. You will have to write this in and remind the administrative assistant who calls to schedule a hearing that this is the type of hearing you desire.

      - At the hearing, hospices may choose to have medical directors and nurses available to testify. The medical director is particularly important if the clinical eligibility of a patient is at issue. Administrative Law Judges have limited medical information and are always very happy to hear from doctors and nurses regarding clinical information. Hospices are to submit all written evidence at the Reconsideration level. However, they may submit additional written evidence to the ALJ as long as the ALJ finds “good cause” for the late submission. Furthermore, even if the ALJ rejects the additional written evidence, the hospice is not precluded from discussing the contents of the additional evidence at the hearing, and the ALJ may permit the hospice to read the additional evidence into the record.
The hospice should approach the ALJ hearings as an opportunity to educate. Some judges will know relatively little about hospice law or policy, so hospices should approach the hearing with the mindset that they will be educating the judge.

- **Medicare Appeals Council**
  - **Time Frames:**
    - The appeal is due within 60 days of receiving the ALJ's decision.
    - The Medicare Appeals Council must issue a decision within 90 days of receiving the request for review.
  - **Details about this level of review:**
    - This is generally a paper review.
    - The Medicare Appeals Council has the authority to go back and review all claims again, including a re-review of claims that have been decided at the ALJ level in certain circumstances.
    - The Medicare Appeals Council generally focuses its review on an ALJ decision where the ALJ misapplies the law or the facts of the case; in these cases, the hospice should appeal to the Medicare Appeals Council.

- **Federal District Court**
  - The appeal is due within 60 days of receiving the Medicare Appeals Council's decision.

(* Note that hospices do not typically appeal standard claim denial cases to the Medicare Appeals Council or to Federal District Court due to limitations on appeals at these levels.)

- Tips and steps below will help a hospice minimize the disruption created by ADRs, and put the hospice in the best position to respond effectively to the ADRs and move off the probe or edit as soon as possible. In addition, when appealing a payment denial, the strategies and suggestions below will give the hospice the best chance of overturning the denial.

**Tips for Dealing With ADRs and Probe Edits**

- **Routinely monitor the Fiscal Intermediary Standard System (FISS) claims inquiry system to determine ADR requests and track ADR responses.** To ensure timely notification of ADR requests, hospices should regularly check the FISS system because the timeframe for response is only 45 days. The FI/MAC may not communicate the outcome of the ADR by standard mail, so the provider will need to continue monitoring the claims status specific to the patient. The hospice should also track the ADR requests and responses on a spreadsheet or grid that includes applicable deadlines for response. This not only helps the hospice keep track of the status of ADR responses, but will be useful if the hospice chooses to appeal any claims that are denied as part of a
probe.

- **Check the system for ADR claims to confirm receipt** of your medical records in response to the ADR. This confirmation step is also available for appeals sent to the QIC.

- **Track your appeals.** If you have not received a response to an appeal within 60 days of submission, begin calling the FI/MAC and/or QIC bodies. You may be told that 1) “Claim is not in the system,” even though you have the mailing tracking information and know it was delivered. (Knowing this allows time to resubmit.) or 2) No claim found. Many appeals can be salvaged by closely tracking status “at the back end” as well as at the “front end.” If a hospice has a reconsideration appeal with MAXIMUS Federal Services, it can track the appeal at [http://www.q2a.com/q2a/q2a.nsf](http://www.q2a.com/q2a/q2a.nsf)

- **Ask to reduce the number of claims in the requested sample, if applicable.** In provider-specific probes, the Fiscal Intermediary generally requests to review a set number of claims, often between 20 and 40. For hospices with a small census, it might take the Intermediary several months to be able to gather enough claims to complete the probe, and the hospice would be faced with severe cash flow issues while the claims are caught in the probe. A hospice in this situation should ask the Intermediary to reduce the number of claims pulled in the probe to a more reasonable number based on the hospice's census.

- **Continue to bill claims while in a probe.** Hospices sometimes make the mistake of ceasing billing when in a probe. However, this will simply prolong the probe, because as discussed above the Intermediary will need to pull billed claims in order to complete its probe. The irregular billing patterns may also raise additional questions with the Intermediary.

- **Submit a cover letter with ADR responses.** By submitting a cover letter highlighting the evidence that supports patient eligibility, the hospice stands a better chance of avoiding payment denials and targeted medical review. The cover letter should be written persuasively and concisely (approximately two pages) to make the hospice's case for patient eligibility during the claim period at issue and point to documentation that supports the hospice's position. As appropriate, refer to or use the ‘language’ of the CoPs, LCDs, published articles describing current best practice, and other documents in describing your rationale and decisions. The ‘status’ of the patient (alive or deceased) should be included on the cover letter with each level of appeal. Patient status does change throughout the process.

- **Use a highlighter** and highlight key information in the submitted medical record (i.e., assessments, clinical notes, etc.) where the documentation helps support the hospice's position. It makes the medical record a much quicker read for the medical reviewer.

- **Include scholarly articles** about the disease that supports a patient’s eligibility, especially if you are dealing with an unusual diagnosis and document in your letter how the patient in question compares to the article. LCD ‘criteria’ are quite outdated in several disease specific groupings, and more recent publications about a specific diagnosis or intervention are important evidence.

- **Consider requesting an educational call.** If the hospice receives a significant number of denials as part of a probe, the hospice may request an educational call between the Intermediary and hospice staff. These calls are an opportunity for the hospice to ask
questions and to hear what intermediaries look for in reviewing ADR documentation; the calls also signal to the Intermediary that the hospice is making a good faith effort to improve its performance and is taking this process seriously.

- **Include documentation from other claim periods, if helpful.** The terminal condition of a hospice patient will occasionally plateau, or even briefly improve, during a month. This does not mean that the patient is not terminally ill, however. In this case, it is often helpful to provide documentation from claim periods outside those requested on ADRs to show the trajectory of the patient's disease, along with a carefully crafted cover letter explaining the information and its relevance to the ADR period.

- **Include supporting documentation** from attending physician visits, hospitalizations, and other documents that augment your appeal.

- **Copy the records.** Make a copy of the patient's records. Number the copy using some sort of prefix that is specific to that patient, for example, using the patient's initials and the page number. The process recommended is to make one copy of the original file, put the numbering in place on each page (right hand bottom corner is standard), then make a copy of the numbered set to send to the Intermediary and keep an exact copy set for the files. This system enables the provider (and Intermediary) to realize if a page is missing, and it is easier throughout the appeals process if everyone can reference the same page. If additional documentation is submitted at the QIC level, the numbering should continue from the first submission as opposed to starting again. Note that the ALJ may re-order the record and will number the pages of the record once the appeal reaches the ALJ. Hospices should request a complete copy of the case file at the ALJ appeal.

- **Send each ADR response separately.** When hospices package ADR responses together, the combined responses will occasionally be misplaced by the Intermediary. Although it is a little more work from an administrative perspective, it is always safest to send each ADR response separately, with a separate cover letter. Hospices should also consider sending the packages via overnight delivery or other means by which timely receipt can be assured and tracked. Be sure the correct address and mail code are included as well as the name and contact information of one knowledgeable person at your hospice for the Intermediary reviewer to reach if necessary.

- **Never send original medical records and always keep a copy of the ADR response.** Hospices should send copies of the medical records requested in the ADR as well as those additional documents that the hospice believes are relevant (as discussed above). Original records should always be retained by the hospice. It is important for the hospice to retain an exact copy of the information provided to the Intermediary in response to an ADR. If the claim is denied by the Intermediary and the hospice decides to appeal the denial, the hospice can use the ADR response as the basis for its appeal to the Intermediary.

- **Know your Intermediary and understand the probe.** Each Intermediary treats ADRs slightly differently. It is important to know the standards that your Intermediary has set when a hospice is placed on targeted medical review. Understanding the type of probe that you are in will be important as you respond to the ADRs. If you are unsure, contact your Intermediary.

- **Document!** The most important strategy for successfully responding to an ADR is a proactive one – clearly and carefully document the patient's condition and the services
provided so that the documentation submitted with an ADR response leaves no doubt of the patient's hospice eligibility. Local Coverage Determinations ("LCDs"), while not the legal standard for hospice eligibility, are strictly followed by reviewers evaluating ADR responses. As a result, a hospice should integrate the LCD into its admission, certification and IDT meeting processes, and educate nursing staff on LCD elements such that the patient's clinical record will show that the patient's condition meets the LCD whenever possible. If you are having trouble with documentation, consider hiring a hospice consultant to help staff with effective strategies to improve documentation.

**Tips for Dealing With The Medicare Appeals Process**

- **Draft a persuasive cover letter.** Just as a cover letter is important in a hospice's response to an ADR, the cover letter becomes even more important when submitting a Medicare appeal. The hospice can modify the cover letter it submitted in response to the ADR to address the specific issues raised by the Intermediary in issuing its claim denial. Developing an effective letter at the redetermination level increases the hospice's chance of success early in the appeals process. Furthermore, the same letter can be easily modified to use for the reconsideration request and the request for an ALJ hearing as well. ALJs have also been requesting that appellants file "written statements." An effective cover letter can be used to satisfy the "written statement" requirement.

- **Understand your weaknesses.** Hospices should objectively evaluate whether to pursue an appeal of a claim denial based on the patient's condition and the hospice documentation for that claim period. Even if weaknesses in a case are not addressed in the cover letter to the Intermediary or QIC, the hospice will need to be prepared to respond to the weaknesses in a case if the ALJ raises them at a hearing.

- **Stay organized.** A tracking tool is important to allow the hospice to keep on top of appeal deadlines. Develop a system to monitor approaching deadlines to ensure that your hospice does not miss deadlines and the opportunity to appeal. For purposes of complying with filing deadlines, note that in general, it will be presumed that the hospice receives notification of a denial 5 days after the date of the denial, unless there is evidence to the contrary, and appeal requests will be considered filed on the date they are received by the appropriate entity.

- **Consider requesting consolidation of appeals for multiple claim periods.** If a hospice has multiple payment denials for the same beneficiary, consider whether to request that the Intermediary, QIC or ALJ (depending on the level of appeal) consolidate the denials into one appeal request. This can have the benefit of reducing some administrative burdens of appealing the claims separately, and allows the hospice to more effectively show the patient's disease trajectory over a period of time. Claims can only be consolidated if they are at the same level of appeal, and with the approval of the appeal body.

- **Consider hiring an outside clinical consultant.** If needed, outside clinical consultants can bring a voice of objectivity to claims that were denied for clinical reasons. Clinical consultants can write a letter in support of eligibility if the hospice appeals a denial, but, just as importantly, they can let the hospice know when they believe that the documentation does not objectively support eligibility. They can also work with a hospice on process and documentation improvements that could reduce future claim denials.
• **Addressing LCDs.** For the purposes of Medicare appeals, there are several important things to remember about the LCDs. First, the LCDs are not the same thing as the legal requirements for hospice eligibility. QICs, ALJs and the Appeals Council are not bound by LCDs, but they will give them substantial deference if they are applicable. Second, the LCDs are not always precise; some of the standards may be subject to interpretation or may be based on outdated information. Finally, most of the LCDs include disclaimers that patients may still be eligible for hospice care, even if they do not meet all of the elements of the LCD, if there are other reliable indicators of a terminal condition. In general, the cover letter should address the LCDs, and should discuss why the patient met the LCD, or, if the patient did not meet every element, what other factors supported a terminal prognosis. A hospice should not feel that it cannot appeal a case because the patient did not meet every element of an LCD. EVERY LCD section that applies to the patient and their diagnosis should be addressed.

• **Make it easy for the decision-maker to find in your favor.** All of the contractors are facing a backlog of cases, and it is possible that the key facts in your case will get lost in the shuffle if you do not point them out clearly to the reviewer. Make it easy for the reviewer by organizing the medical record in a coherent fashion and making key documentation easy to find. Denials can sometimes result from the contractor failing to see a document in the medical record. Attaching key documentation as a separate exhibit, or pointing out where it can be found in the medical record, can help minimize these issues.

• **Learn from the process.** If a claim payment was denied because the documentation did not support eligibility, try to understand what part of the documentation was perceived to be insufficient and develop strategies to address the issue. If you find yourself subject to a number of technical denials, for example, reevaluate your certification processes and notice of election forms.

• **Network with other hospices** who are served by the same FI/MAC to share the experience so that you can develop a process that works for your organization.