CMS CR8425: Expansion of Claims Review to Related Claims
Compliance for Hospice Providers
March 2014

CMS issued Change Request (CR) 8425 on February 6, 2014 with an implementation date of March 6, 2014. In the CR, CMS has announced additional guidance to Medicare Administrative Contractors (MACs), Recovery Audit Contractors (RACs) and Zone Program Integrity Contractors (ZPICs) to expand their authority for automatic denials for “related” claims when the claim is related to others that have been denied as a result of pre or post-payment review. Contractors are not required to issue Additional Documentation Requests (ADRs) for the “related” claims prior to issuing the denial. CMS states “Claims will be deemed "related" if documentation associated with one claim can be used to validate another claim.”

Details about CR8425

- **What CMS contractors does this apply to?** CMS has announced that the guidance applies to MAC, RAC and ZPIC contractors.

- **Previous contractor authority:** Prior to the issuance of this CR, contractors explicitly did not have the authority to do this as part of the additional documentation review (ADR) process but now they do (before the manual said “shall not deny other claims submitted before or after the claim in question unless appropriate consideration is given to the actual additional claims and associated documentation”).

- **Contractor discretion:** Contractors have the discretion to institute automatic claim denials for “related” claims, but are not strictly required to do so.

- **How could the contractor implement this new authority?** With this authority a contractor could, after reviewing documentation for one claim, deny previous or subsequent claims without a record review if the other claims are “related” to the claim in question.

- **How is “related” defined?** A “related” claim is vaguely defined, as claims are considered related "if documentation associated with one claim can be used to validate another claim." The guidance makes clear that the examples listed, which focus on inpatient and diagnostic claims, are not exhaustive but are only examples.

- **What does this mean for hospice providers?** It appears that CMS contractors could use automatic claim denials in hospice, but it is uncertain at this point how
they will exercise this authority, including what types of claims denials will result in other claims being automatically denied, for how long subsequent claims be could be denied without record review etc.

**What should hospices do?**

- Notify NHPCO if any of your claims are subject to automatic denials. At this writing, it is unclear how this will be implemented by the various contractors and NHPCO is interested in gathering more data from providers on how it is being implemented. Send examples of automatic denials to regulatory@nhpco.org. We will use your examples in further advocacy with CMS around this issue.

NHPCO is following this issue carefully and wants to determine impact on hospice. Your feedback is critically important as we consider next steps. Please let us know as your hospice experiences this “automatic denial” issue because the claim is considered “related.”