New Audit on GIP Claims

To: NHPCO Provider Members
From: Health Policy Team
Date: March 13, 2017

Background

Recently, NHPCO has received calls from hospice providers where they received a medical records request from CMS and StrategicHealthSolutions, LLC for patient GIP stays. We reached out to the CMS Center for Program Integrity for more details on this new audit, why it is being conducted and what providers should do to comply.

Summary

Based on our conversations, we learned that CMS has contracted with StrategicHealthSolutions, LLC as a Supplemental Medical Review Contractor (SMRC) for a review of patient GIP stays, in response to the OIG report on General Inpatient Care (GIP) published in March 2016. Approximately 65 hospices are a part of the audit. NHPCO reached out to CMS Center for Program Integrity to get more details on the audit, the audit process, and the process for discussion and education of the audit findings.

Hospice Project Background

The U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG) issued a report in March 2016 titled, “Hospices Inappropriately Billed Medicare Over $250 Million for General Inpatient Care.” In response to the report, CMS has directed StrategicHealthSolutions, LLC, as the Supplemental Medical Review Contractor, to conduct post-payment review of claims for calendar year 2015 to identify claims for GIP care that may have been improperly paid under the Medicare Part A benefit.

Audit Details:

Details on the nationwide audit:

- In general, the sample was selected based on length of stay
- Providers were identified by random sample
- Approximately 65 providers will be included in the project
- No more than 40 records/claims per provider will be requested
- CMS does not plan to perform extrapolation on this project
Elements of the Supporting Documentation Requested of Note

The SMRC has asked for the following supporting information. This list is not complete, but is an indication of their specific documentation interests:

- Documentation to support a precipitating event for GIP care such as pain control or acute or chronic symptom management that cannot reasonably be provided in other settings
- Documentation to support that interventions tried in the setting prior to GIP admission were unsuccessful
- Documentation to support pain control
- Documentation to support symptom control
- Hospice Plans of Care (POC) covering the entire GIP stay to support change in the level of care including the beneficiary’s response and collaboration with physician services, nursing services, medical social services, and counseling
- Any other documentation to support GIP care
- Physician orders
- Physician progress notes
- Physician consultation documentation
- Signatures/credentials of professionals providing services
- Copies of any patient notices given (e.g., Advance Beneficiary Notice of Noncoverage)

ADR Requests

**Guidelines for record submission:** Providers should submit the requested information to the SMRC by the record due date/response date contained in the ADR letter. Please note, that providers can request an extension if the request is made to the SMRC before the record due date/response date found in the ADR letter.

**Requesting an extension:** If the provider fails to send in the requested documentation or contact the SMRC for an extension by the record due date/response date contained in the ADR letter, the provider’s claims will be recommended for denial and the Medicare contractor will initiate claims adjustments or overpayment recoupment actions for the undocumented services. We encourage the providers to request an extension, as needed.

Discussion/Education

**Review Results Letter:** Once the medical review project is completed, providers should receive a Review Results Letter containing information regarding the claim(s) and the specific review findings associated with these claim(s). As a representative of CMS, the SMRC offers an opportunity for a Discussion/Education Period as a result of the medical review findings.

**Discussion/Education Period:** The Discussion/Education Period is intended to allow for the re-review of specific claim denial recommendations, deliver rationale and education for the medical review findings, and provide information on how denials can be avoided in the future. Additionally, if a provider determines there is additional information and/or documentation relevant to supporting payment of the claim(s) recommended for denial, the provider may submit the additional information and/or documentation. The Discussion/Education period is
not part of the appeals process and does not in any way, alter the provider’s rights to appeal. Timeframes to request a D&E will be found in the Final Review results letter the providers will receive from the SMRC when the project is complete.

Visit the Discussion/Education section on the SMRC website.

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**What is the Supplemental Medical Review Contractor (SMRC)?**

As the Supplemental Medical Review Contractor (SMRC), StrategicHealthSolutions, LLC has been contracted by CMS Center for Program Integrity to serve as a Supplemental Medical Review Contractor (SMRC), to perform and/or provide support for a variety of tasks aimed at lowering the improper payment rates and increasing efficiencies of the medical review functions of the Medicare and Medicaid programs. One of their primary tasks will be conducting nationwide medical review as directed by CMS. The medical review will be performed on Part A, Part B, and DME providers and suppliers to determine whether Medicare claims were billed in compliance with coverage, coding, payment and billing practices.

The selection of topics and time frames to be reviewed is determined by and at the direction of CMS. The focus of the projects may include, but are not limited to issues identified by Federal agencies, such as the Office of Inspector General (OIG), Government Accountability Office (GAO), CMS internal data analysis, the Comprehensive Error Rate Testing (CERT) program, professional organizations and First-Look Analysis Tool for Hospital Outlier Monitoring (FATHOM) report and Program for Evaluating Payment Patterns Electronic Report (PEPPER). The SMRC is conducting medical review based on the analysis of national claims data versus data that is limited to a specific jurisdiction as performed by Medicare Administrative Contractors (MACs). Unlike the MACs, the SMRC does not perform claim payment functions.

For additional questions, please contact NHPCO at regulatory@nhpco.org.

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