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Eli's Hospice Insider

Reimbursement: Combat These Common Denial Reasons With 3 Expert Pointers

MAC reveals threshold for getting off TPE review.

Could you survive if half your claims got denied on a regular basis? If not, you'd better make sure your documentation is shipshape, a recent MAC probe shows.

HHH Medicare Administrative Contractor **Palmetto GBA** recently performed a pre-payment service-specific probe medical review on hospice claims for Routine Home Care Services, the MAC says on its website. The probe covered claims from March through May of this year in all settings.

The result: Palmetto released results for two of the probe's four regions, and the denial rates were steep. The MAC either partially or fully denied 47 percent of the 92 claims reviewed from Arkansas, New Mexico, Oklahoma, and Texas. Palmetto denied $112,158 of the $243,596 reviewed, resulting in a charge denial rate of 46 percent. And Palmetto denied 45 percent of the 92 claims it reviewed from 25 other states. The charge denial rate was a somewhat lower 36 percent in that region, however.

In both geographic areas, the top denial reasons were Physician Narrative Statement Not Present or Not Valid, No Valid Election Statement Submitted, No Plan of Care, and Documentation Submitted Does Not Support Prognosis of Six Months or Less, Palmetto reports. Failing to respond to the Additional Development Request also ranked high on the denial list.

What lies ahead: Those denial stats indicate that hospices may have a rough road ahead with the Targeted Probe & Educate medical review procedures that the **Centers for Medicare & Medicaid Services** had directed all MACs to use. Under TPE, hospices will stay on review through three rounds of review if they have high denial rates, and then may be referred to a fraud contractor or other authorities for scrutiny (see story, p. 92).

Just how high must those stats be to keep them on TPE? Up until recently, Medicare Administrative Contractors would say only that vague aberrant billing stats or undefined high claim error rates would land HHAs on TPE. On its TPE website, the **Centers for Medicare & Medicaid Services** said agencies would come off TPE by performing well, meaning demonstrating "low error rates or sufficient improvement in error rates, as determined by CMS."

But now, HHH Medicare Administrative Contractor **National Government Services** has said in a recent TPE webinar that TPE applies when "a high payment error rate above 15 percent" occurs. Providers must have a PER "of less than 15 percent in order to be released from additional rounds of review" under TPE, the MAC clarified.

MAC **CGS** has already designated a topic for its first hospice TPE campaign (see Eli's Hospice Insider, Vol. 10, No. 11), and Palmetto mentions in this article that it will be launching TPE.

Silver lining: While hospices are likely to find TPE challenging, it may also have some benefits for providers, hopes **Carrie Cooley**, COO with **Weatherbee Resources** in Hyannis, Massachusetts.

Under the program, MACs are supposed to provide hospices with real-time feedback on their claims denials to help them correct similar problems in the next round, or even in the same round of review. This process, and the required time gap between review rounds, should allow hospice providers to make timely changes in forms to reduce future technical errors like missing language on the election statement or physician narrative forms, Cooley says.

Cooley is optimistic that the focus of TPE will change medical review from its more punitive approach now to a more collaborative model, which in turn will help hospices to show significant improvements in reducing denials and increasing

claims paid. The TPE model's intention to decrease provider burden during probe review, reduce appeals, and improve the medical review and education process is "great news," Cooley says.

Pay Attention To This Critical Advice

Two of the top denial reasons in Palmetto's high-denial-rate probe, "Physician Narrative Statement Not Present or Not Valid" and "No Valid Election Statement Submitted" frequently boil down to "forms issues," Cooley judges. Hospices often neglect to update their election statement or physician narrative forms when new requirements are issued, resulting in technical claims denials.

For example: Palmetto notes that "the narrative shall include a statement under the physician signature attesting that by signing, the physician confirms that he/she composed the narrative based on his/her review of the patient's medical record or, if applicable his or her examination of the patient." "Composed" is the key word in that requirement, Cooley stresses. The form a hospice uses may simply leave out that statement under the signature, opening up a claim to a denial.

Another example: Palmetto points out that an election statement must include "the individual's or representative's acknowledgement that he or she has been given a full understanding of the palliative rather than curative nature of hospice care, as it relates to the individual's terminal illness." Some hospices' election statement forms don't include that palliative-versus-curative care language, Cooley reports.

One of the biggest election statement pitfalls hospices encounter is neglecting to put the attending physician designation on their forms, Cooley says.

CGS notes on its Hospice Election Requirements webpage that the election statement must include "the patient's or representative's designated attending physician (if they have one). Include enough detail to clearly identify the attending physician. This may include, but is not limited to, the physician's full name, office address, or National Provider Identifier (NPI)." (For CGS's list of election statement requirements, see story, p. 89.)

Heed Cooley's advice to avoid denials like the ones Palmetto made in its latest probe:

1. Review forms at least annually. Hospices should have a formal process to review their documents for compliance at least once a year, Cooley advises. A good time is after the annual payment update rule is finalized, so you can incorporate any changes from the rule.

2. Destroy outdated forms. Don't be tempted to use up your old forms before switching over to updated ones, or to ignore the old forms floating around.

Avoid this scenario: A common opportunity for noncompliance is when one of your nurses who works only on the weekend pulls an old form out of the packet in her car because that's all she has on hand, Cooley gives as an example. Make sure you round up all the old admission packets and other paperwork and destroy them when you replace them with a new version.

3. Implement a pre-billing audit. Hospices should have an effective process in place to ensure the validity of all their forms, as well as other requirements, before billing, Cooley emphasizes. That way hospices can fix any problems before it's too late.

The old adage "an ounce of prevention is worth a pound of cure" definitely applies to hospice billing and the burden of implementing a pre-billing audit, she says. "A solid pre-billing verification process prevents about 95 percent" of the types of errors seen under these top denial reasons, Cooley tells **Eli**.