MDS Alert

Compliance: Be On Your Toes When Handling MAC/FI Probes

Failing to include the right MDSs can cost you big time.

What you don't know can hurt you during a MAC or FI probe review. Follow these three essential steps to avoid unnecessary payment denials and appeals.

1. N ail down what you need to provide to the MAC or FI. "The contractor will identify the reason for the additional development request (ADR) based on a specific reason code in the Fiscal Intermediary Shared System (FISS)," says **Betsy Anderson,** VP of FR&R Healthcare Consulting in Deerfield, Ill. She advises printing out the narrative explanation of the reason code in the FISS, "which lists all the required documentation the contractor wants submitted."

Important: Then make sure you include everything on that list, along with a copy of the ADR on the top of the packet and a copy of the UB- 04, Anderson advises. Some SNFs also send a cover letter to help paint a clear picture of the resident and his covered care. Doing so isn't mandatory, says Anderson, but it can help focus the reviewer's attention on "things you want them to see."

Check this: In a Part A review, sometimes all bets may be off in terms of claims denials if you don't include the correct MDSs, says Anderson. "And so many times, one claim can involve multiple MDSs," she says. "So it's really critical to include that information based on the time period of the claim." But don't limit what you include just based on the dates of services because "the lookback period may extend back to a prior MDS, as well."

Tip: Copy everything singlesided and make sure the copies are legible and include the edges of the paper, advises Anderson. "We advise either stapling the entire packet or using a rubber band to hold it together."

Avoid using a bunch of paper clips. And don't mail it without making a copy for your own records so you'll know what the FI or MAC has when it's doing its review, she adds. For a provider-specific probe review, the Medicare contractor will typically examine 20 to 40 claims, says Anderson, who notes that CMS has not indicated that this is a maximum number. She hasn't seen contractors go any higher than 40 claims.

2. Use a **team approach with a point person.** The designated point person is the communicator who "drives the boat, so to speak," for the probe review and verifies that the facility is getting things in on time, advises Anderson.

3. Meet the required timelines. "Most contractors have a 45-day time frame to respond to ADR requests" for both prepayment and postpayment reviews, says Anderson. She has, however, seen some FIs ask for information within 30 days. "The ADR information must be received and logged into the contractor's system in order to be considered timely," she adds.

Delay, you pay: If the FI or MAC doesn't receive the information on a timely basis, it will deny the claim and the facility will have to file a formal appeal (redetermination), Anderson cautions.

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