

Medical Review Progressive Corrective Action: Understanding the Process and Ensuing Access to Care

Increasing access to care while ensuring regulatory compliance has presented a real challenge to hospices over the past several years. Operation Restore Trust, anti-kickback concerns, medical review and focused medical review, issues of "unbundling" and free care have for many, imposed a chilling effect on access to appropriate hospice care. Claim denials and Program Integrity Investigations raise real financial and regulatory risk. However, hospices are encouraged to remain mission-driven and to admit all appropriate patients who want hospice services and who qualify for them.

United Government Services and its Medical Director, Dr. James Cope, M.D. have demonstrated a sincere willingness to help hospices through the minefield of regulatory and financial concerns. Dr. Cope spoke with me recently and explained that UGS, as well as all other fiscal intermediaries ("FIs") are required to follow Program Memorandum AB-00-72 regarding Medical Review Progressive Corrective Action (PCA). This CMS Program Memorandum, dated August 7, 2000, requires FIs to follow these steps:

- Conduct medical review based on data analysis, which ". . . is an essential first step in determining whether patterns or claims submission and payment indicate potential problems."
- Validate potential problems by conducting "probe" reviews. The FI is required to take the interim step of selecting a small "probe" sample of potential problem claims to ascertain whether such claims are being billed in error. This means that medical review activities should be targeted at identified problems.
- Only subject hospices and other health care providers to the amount of medical review necessary to address the nature and extent of the identified problems. In the Program Memorandum, it is noted that "a small level of non-compliance would not warrant 100% prepayment medical review."
- When requesting additional documentation for medical review purposes, notify hospices that the requested documentation is to be submitted to the contractor within 30 days of the request. If the necessary documentation to

POSTED:

Nov 30, 2001

RELATED PRACTICES:

[Health Care](#)

<https://www.reinhartlaw.com/practices/health-care>

RELATED SERVICES:

[Hospice and Palliative Care](#)

<https://www.reinhartlaw.com/services/hospice-and-palliative-care>

make a medical review determination is not received within 45 days of the request, the FI is instructed to make a determination based on the available medical documentation.

- Consider the provider error rate in deciding how to address a billing problem, give provider feedback and education as an essential part of solving problems. This provision in the Memorandum is extremely important and UGS takes its education role very seriously.
- Offset or collect all overpayments. If medical review detects possible fraud, it must be referred to the Fraud Unit.
- Track interventions (reviews and educational contacts) with regard to individual hospices through a provider tracking system.
- Track and consider the results of appeals. FIs are instructed to use medical review resources as efficiently as possible. When a large number of claims denials are overturned on appeal, FIs are required to take steps to understand why this is, and to discuss appropriate changes in their own policies, procedures, outreach or review strategies.

UGS is required to educate providers about the above concepts. In my experience, UGS is taking this role very seriously and is available to hospices to problem-solve. For example, if your hospice wishes to admit a patient and it is not clear whether the prospective patient is eligible under LMRPs or otherwise, a contact may be made by your medical director to Dr. Cope. He may be reached at United Government Services, 414-226-6080. Also, when UGS issues an ADR, it is important to know that UGS does not limit your hospice to the claim period in question. All documentation that lends credence to the position that the patient is hospice eligible may and should be included. Before any claim is denied for reasons of prognosis, Dr. Cope himself will review the file.

For hospices, the lesson is to continue to serve all eligible patients. UGS will look at data and will focus on outliers. Questionable admissions can be discussed up front with UGS. Once UGS questions a claim, submit all data that may be reasonably relevant to your hospice's determination that this patient was eligible. Err on the side of overinclusion. However remember that documentation is critical. Make sure that your hospice is very aware of any applicable LMRPs and that documentation clearly reflects adherence to eligibility criteria. In the event that an admission or extension of coverage under the Medicare hospice benefit is



in question, the case may be discussed with Dr. Cope or representatives of UGS. In hospices' concern for meeting the regulatory requirements, it is essential that the pendulum not swing too far. All patients who qualify and who need and want hospice services should have access to them.

These materials provide general information which does not constitute legal or tax advice and should not be relied upon as such. Particular facts or future developments in the law may affect the topic(s) addressed within these materials. Always consult with a lawyer about your particular circumstances before acting on any information presented in these materials because it may not be applicable to you or your situation. Providing these materials to you does not create an attorney/client relationship. You should not provide confidential information to us until Reinhart agrees to represent you.