Reimbursement, Billing, ADRS and Claim Appeals – RHHIs and Program Safeguard Contractors

Sequential billing has long posed a significant problem for hospices under medical review edit. Because of sequential billing, some hospices have found themselves waiting many months to adjudicate claims, leaving payments in the queue and in some cases, financially threatening the viability of the hospice.

On April 29, 2005, CMS issued Transmittal 552 which revises the Medicare system so that delays will be minimized. In its Transmittal, CMS stated:

"Responding to the requests of hospices to provide relief from these delays, CMS has determined that Medicare systems can be revised to decrease them. (emphasis supplied) The edits in Medicare systems are themselves sequential, firing in a predetermined order. This order will be changed. As of the effective date below, the edits that enforce sequential billing will be moved from their current position prior to the medical review process to a position after all medical review edits. As a result, any hospice claim that will be subject to review will trigger a request for records immediately upon receipt, rather than being held while previous record requests are being processed. By making the record request and review periods for multiple hospice claims simultaneous, delays to hospice claims may be reduced. Once released from medical review, if a claim is found to be out of sequence it will be held at that later point, when record request delays no longer affect it."

While this change, which goes into effect October 1, 2005, will not alter the fact that hospice claims are subject to review, it will assist those hospices that receive ADRs or claim denials for patients who are still considered eligible by the hospice and still receiving hospice services.

Hospice are encouraged, as always, to carefully review eligibility and level of care decisions. When there is a disagreement with the RHHI, hospices are encouraged to advocate on behalf of their patients and continue to serve these patients during the appeal process. Following is a checklist for addressing claim denials and additional documentation requests.

- Understand eligibility criteria.
- Ensure proper documentation.

A. Eligibility

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B. Level of care

- Know the difference between ADR and fraud investigations.
- If it's the fraud unit, don't wait, contact legal counsel! On initial ADR, prepare summary and highlight documentation that supports eligibility in light of relevant LMRP/LCD or Unipolicy.
- Request educational conference.
- Ask questions and develop rapport with the RHHI. Do not discharge eligible patients and include appeals in your budget as a cost of doing business (but know when to discharge).
- Know the appeals process and timelines for appeal. Be prepared to go to hearing.
- When necessary hire consultants to help."

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