Clinical Record Request for Review by External Contractors

Home health agencies are receiving significantly more requests for clinical records at both pre- and post-pay reviews. The record reviews may be received by the: 1) Medicare Administrative Contractor (MAC); 2) Comprehensive Error Rate Testing (CERT); 3) Recovery Audit Contractor (RAC); or Zone Program Integrity Contractor (ZPIC) under current contracts in place with CMS.

Notice of request for records can come from the electronic payment system in the form of Additional Documentation Requests (MAC ADRs), from written notices (RAC, CERT, or ZPIC), or from a walk-in request. The notification, regardless of the method, will identify the response time allowed for submission of the record and the acceptable method of delivery. (e.g., fax, electronic, hard copy). The home health agency must pay immediate attention to the request as these are time sensitive, and denials due to failure to respond timely carry considerable risk for additional requests from the contractor. It is also very important to identify the review period requested, which is generally one or two episodes, and the specific documents that are requested.

Any response to a request for clinical records should be promptly assigned to the agency’s designated manager or supervisor so that preparation of the record can begin immediately. MJS recommends that the agency have a “Record Review Team” assigned to:

- assure that competent clinicians review the data before submission,
- assure that a summary can be prepared, if time permits,
- assure that the response is screened by a second or third pair of eyes to reduce the risk of mistake or oversight,
- track the status of the request through the respective contractor records, and
- Initiate timely and appropriate appeals of denied payments.

In addition, the agency must incorporate corrective action into its operations whenever deficient charting is identified, whether this is following a state survey or a denial of payment.
The agency may be exposed to a formal Progressive Corrective Action initiative by the MAC, requests for more episodes to review, significant overpayments or extrapolations from the ZPIC, or even suspension or termination from the Medicare Program in serious situations.

This guide is divided into three parts to assist the home health agency in Reviewing, Responding and Resolving clinical documentation requests that may result in denials of payments. Information is provided as “MJS recommendations” for best practice guidance in processing record requests – from processing the request, to preparing summaries, to appealing denials and finally, to implementing corrective action that prevents denials of payment in the future.
Conducting a Clinical Record Review and Response Plan

Record Review Team composition:
RN with home health field experience, and excellent Medicare coverage knowledge
PT, OT, and SLP with home health experience (for any rehab chart request)
Clerical staff representative
Billing clerk or manager
Marketer
Clinical Supervisor

Record Review Procedure

1. Clerical representative or RN enters the record request to a Request Log that allows for tracking and for ongoing action until the claim is finalized. This log should be maintained in current status at all times and should be incorporated into the agency’s QAPI or Compliance Plan.

2. Clerical representative prints or copies requested period, checks the order of the record (date order), and paginates record.

3. Clerical representative prints copy of bill from Medicare DDE system or comparable for use in the review.

4. Package is organized as follows:
   a. Copy of request from the Contractor
   b. Copy of the bill
   c. Copy of the requested clinical record

5. Assigned RN audits the record using the Record Review Audit Tool or comparable form using the billing data to determine the date of the visit, the HCPCS code billed, the units of time billed, and the date billed in the payer’s system.

6. A deficiency that is identified as “technical, unable to appeal”, should be documented on a copy of the respective visit note and labeled as “billing adjustment needed.” This should be forwarded to the biller for bill adjustment. If within the allowable time frame
7. A deficiency that may result in a “homebound” denial risk may require a beneficiary interview by the RN (may be conducted by phone or in person if the patient is still on active service)

8. A deficiency risk that may be supported with other documentation that can be divided into the following four categories:
   a. Supported by additional documentation from another period retrieved and labeled as “supplemental” data from prior clinical documentation
   b. Supported by additional documentation from other providers (hospital, laboratories, rehab facilities, physician treatment records, etc.) – assigned to the marketer or clinical supervisor for retrieval from the outside provider
   c. Supported by a summary provided by the attending physician (attestation or medical necessity statement) – assigned to the marketer or clinical supervisor
   d. Supported by a summary written by the agency’s clinician who has knowledge of the patient and the care rendered during the episode.

9. The RN must assign a timeframe for receipt of the supplemental documentation that will allow the agency to meet the deadline for submission. All members of the response team must be cognizant of the deadline. If the supplemental documentation is not received before the established deadline, the record must be submitted to the Contractor. All attempts to retrieve the supplemental data should continue as this may be used later in the appeal process.

10. Important Note: Late entry to the clinical record should not be considered for records that have been billed and paid. Corrections may not be made to the records after the record has been signed, dated, and incorporated into the medical record. Any additions to the clinical record must be documented on a supplemental form that is dated as of the date of entry, and signed and dated by the professional entering the data. Likewise, an insufficient F2F certification or physician’s order may not be returned to the physician for modification on the form. Supplemental data, properly dated with date prepared, can be attached to the record in the appropriate section.
11. The RN prepares the final record submission packet, paginates, and prepares the final summary. The summary should reference specific page numbers in the record submission packet that will draw the attention of the reviewer to pertinent information.

12. The final packet, with summary and bill adjustment attached to the clinical record data, should be reviewed by the clinical supervisor before submission. If therapy is a component of the care, the PT, OT, or SLP may be involved in the review and preparation of supplemental data at any point in the processing; however, the responsible therapist should always review the final packet before submission when therapy was delivered.

13. The clerical representative should prepare two copies of the final packet and submit one set to the contractor at the address listed on the request letter. All responses should be delivered by a carrier that provides a “delivery receipt with signature” response to the agency. Note: For ADR responses where more than one record is requested, each packet must be separately prepared. MJS recommends that the packets be separately submitted to the contractor.

14. Delivery receipt should be attached to the final packet and held for further action.

15. The clerical representative or RN should check status on the request at least every two weeks. The contractor’s website, if available, should be the source used to track status of the record review.
Writing the Summary

A summary to accompany the record request in not a required step in the response, but it is highly recommended. The purpose of the summary is to provide clear and concise evidence that the requested record meets the payer’s specific requirements for payment. It should be written to focus the reviewer’s attention to the specific documentation that will support the eligibility or coverage determination.

For the Medicare home health claim, the summary should address the following areas:

- Face-to-face certification (if the episode under review is the start of care episode, or if the F2F certification is specifically requested)
- Compliance to physician’s orders
- Homebound status of the patient (at start, during, and at end of episode)
- Medical necessity for the skilled services ordered (identified problems that are addressed during the episode)
- Skilled services rendered to resolve the problems as documented on specific notes
- Need for continuation of services beyond the three-week acute phase follow-up (as documented on specific notes)
- Summary of patient’s health status at start of episode, during, and at end of episode.
- Prior functional status for rehab services
- Rationale for restorative therapy vs. maintenance therapy
- Timeliness of functional re-assessments

If support comes from supplemental documentation, elaborate on the source and reference the page number of the supplemental document. There is no formal template recommended, but MJS does recommend that the summary point to specific documents by page number.

The summary should be signed and dated by the RN. Use the actual date of entry or completion, but be sure that the summary references the period under review.
**The Medicare Appeals Process**

The Medicare Appeals process is a formal process that has designated time points and dollar amount limitations included. All appeals for traditional Medicare, regardless of the provider type, must follow the same procedures. The process time frame begins with the receipt of the Demand Notice from the Medicare Administrative Contactor. If the home health agency files the appeals timely in each of the first two levels of appeals, as specified in the notice, then recoupment can be deferred until the second level of appeal is finalized.

The five (5) levels of appeal in the Medicare process are as follows:

- **Level 1**  
  Redetermination  
  Palmetto GBA

- **Level 2**  
  Reconsideration  
  QIC – MAXIMUS

- **Level 3**  
  ALJ Hearing  
  Office of Medicare Hearings and Appeals  
  Department of Health and Human Services

- **Level 4**  
  Appeals Council  
  Departmental Appeals Board  
  Department of Health and Human Services

- **Level 5**  
  federal district court

In the first two levels of appeal, there is no minimum monetary threshold required to request review. For the ALJ level, a minimum monetary threshold of $140 (for 2013) is required to open an appeal. In the fifth level, at least $1,400 must be in controversy to request judicial review in federal court.

When the external review is conducted by the Recovery Audit Contractor, the provider has a unique opportunity for a Discussion Period that follows receipt of the results letter on complex
reviews. The Discussion Period is not part of the formal appeal process, but it can be helpful in identifying the particular reason for the denial which can be helpful in developing an appropriate appeals process.

The formal Medicare Appeals Process can be reviewed at the following link:
Preparing the Medicare Appeal

The Record Review Team should also serve as the Medicare Appeals Team. Upon receipt of the denial notice, which may be the results letter from the RAC, the following appeal preparation steps are recommended:

1. RN reviews the findings from the external contactor. Review completely the appeal process and allowed timeframe.

2. The clerical representative updates the Record Request Log with the results and the appeals timeframe.

3. If the claim is partially or fully denied, the RN meets with the clinical supervisor to determine if discussion period (RAC) or appeals process is the appropriate decision.

4. If discussion period is opted for the RAC, the RN reviews the copy of the submitted record carefully against the Results Letter, and identifies any areas that refute the denial. These should be written as “notes” for the discussion. Carefully locate page numbers for reference. Contact the RAC at the phone number provided in the letter, and initiate discussion. Make careful notes of the additional information provided by the RAC reviewer. This can be helpful in writing the appeal.

5. The first level of appeal is the redetermination. This level is addressed to Palmetto GBA and is triggered upon receipt of the Demand Letter which should provide the rationale for denial.

6. The RN should review the denial reason and review the submitted record for any areas that refute the denial. Make careful notes of the information with page numbers from the clinical record.

7. If supplemental data is needed from another provider, request the records using the marketer or the clinical supervisor as the team member assigned to coordinate with the other party.

8. The RN prepares a rebuttal response summary that addresses the denial reason with data found in the clinical record or in the supplemental data. The rebuttal should address only the denied services and rationale. If rehab services are denied, consider
having the rehab professional review the documentation and prepare a denial rebuttal for these services. This rebuttal can be separate or a continuation of the rebuttal prepared by the RN. The original summary will make the point for the remaining coverage issues.

9. The clerical person should re-copy or re-print the record and re-paginate for the appeals process. Include the original summary and billing detail. Note: This packet will serve as the official record throughout the appeals process. If supplemental data is necessary at subsequent levels of appeal, the additional documents should be paginated as “addendum to” the appeal package.


11. Attach completed CMS-20027 form to revised record. Make two copies.

12. Clinical supervisor should review the completed packet before submission. If rehab services are denied,

13. Submit original CMS-20027 with copy to Palmetto at the address included in the demand letter by carrier with “receipt to sender” capability.

14. The second level of appeal is the Reconsideration level. Upon receipt of the appeal decision from the Redetermination level, the RN should review the findings as provided by the appeals contactor. The RN and clinical supervisor should determine whether appeal to the Reconsideration level is appropriate.

15. If an appeal to the Reconsideration level is planned, the RN should retrieve a copy of the CMS-20033 form at the following link: [http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms20033.pdf](http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms20033.pdf). Review the deadlines as outlined in the appeal letter. RN completes the CMS-20033 form and prints.

16. The clerical representative should update the Record Request Log with the new deadlines.

17. The RN reviews the reason for denial, and determines if additional, supplemental data is warranted. If so, follow the process in # 6 and # 7 above.

18. RN prepares the rebuttal only for the services and decisions provided in the previous
appeal.

19. Follow the process in # 8 - #13 above.

20. If the Reconsideration level decision is partially favorable or unfavorable, the RN and clinical supervisor should carefully review the findings and determine if a request for hearing at the Administrative Law Judge level (level three appeals) is warranted. The ALJ recommended appeal preparation is included in the following section.
Preparing for an Administrative Law Judge Appeal Hearing

If the home health agency decides to appeal the Medicare denial to the ALJ level, the first consideration is whether the agency will handle the hearing directly or, since this is a formal court hearing via teleconference, have legal representation at the hearing. The amount of the denial and the expert witnesses required to refute decisions such as extrapolation will be important factors in determining whether legal counsel to direct the hearing is necessary. If legal counsel is engaged, the agency should prepare for the ALJ hearing as directed by Counsel.

In preparing for the hearing, the Agency should determine the persons in house who will testify and any outside consultants that may be engaged to provide expert testimony. If experts are anticipated, then legal counsel is usually necessary to assure that the experts are properly vetted before the court. If the agency is representing itself, then consultants can serve as advisors but should not testify in the hearing.

Another decision that the agency must make is whether the beneficiary can or should testify at the hearing. While the beneficiary may be an excellent witness in the areas where they can be properly prepared, remember that the judge can address questions to the witness as he/she feels appropriate. In some situations, the beneficiary or caregiver can unintentionally hurt the changes of appeal if confused.

In preparation for the ALJ hearing, the testifying witnesses should review the record in its entirety (not just the selected episode, as well as all previous denial rationales at all levels of appeal. Be prepared to defend each of the denied reasons, even if a subsequent appeal level did not address the original denial reason. The ALJ can address any of the reasons for denial, at all levels of appeal.

Remember that the record can be supplemented with additional data up to a few weeks before
the hearing date, so it is vital to continue to obtain medical necessity data from other providers if you have been unsuccessful previously.

Also, look carefully and any applicable LCDs that are directly the factor in the denial reasons. Local Coverage Determinations are restrictive to the locale and to the MAC that develops the policy locally. Other regions of the country do not have the same LCDs in place. If the denial rationale is strictly based upon a regional medical policy, the agency can point this out as “discriminatory” to beneficiaries that are in the more restricted areas. This point needs to be made when CMS policy is less restrictive per the Social Security Act or the Medicare Benefit Policy Manual.

The hearing request document for an ALJ hearing may be found at the following link: http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms20034ab.pdf

MJS recommends the following approach for ALF hearings:

- RN with knowledge of the patient testifies as to the clinical needs of the patient that were addressed in the episode. RN identifies the specific interventions ordered by the physician to address the needs. Point out the page associated with the POC and read it!
- RN then points to hospital stays, emergency room visits, medication changes, falls with injury, etc. that occur within 3 weeks prior to the episode or during the episode, and what the agency did to remediate the new problem.
- RN then points to specific documentation in the clinical notes that address the recent problem with the intervention performed, and the outcome. Focus on 5 visits only as this will cover the episode cost.
- RN should always address the homebound status with evidence in the record, or supplemental data, on how the patient met the homebound requirements throughout the episode.
- If therapy is denied, consider whether the PT should testify. Only allow this if the PT is fully knowledgeable of the patient and of Medicare guidelines. You do not want an
argument to erupt between the therapist and the judge. The judge wins.

- Following the clinical testimony, a representative from the agency should address the specific reimbursement criteria that address the services and interventions discussed previously. Quote directly from the Medicare Benefit Policy Manual and explain how the services provided and documented met the coverage requirements. This person may be the administrator, another RN, or a reimbursement expert (consultant).

- If beneficiary or caregiver testimony is appropriate, it should follow the agency’s presentation.

- If the agency presents the ALJ hearing without Counsel, the ALJ level of appeal should be the final level considered. Only if Counsel is involved can the appeals council review or judiciary review in U.S. District Court occur.
Corrective Action Response Evaluation (CARE) Plan

Implementing corrective action following reimbursement denials requires that the home health agency review the requested records, respond with documentation, appeal specific denials, and then analyze the agency’s performance to assure that the deficiencies resulting in denials are not systemic within the agency. It is also important to correct the practice or knowledge deficits that are the underlying cause for the denials.

It is the analysis trended denial occurrences that has often been overlooked in the follow-up by the home health community; thus, agencies have not self-reported overpayments as required by federal statutes. The Patient Protection and Affordable Care Act of 2010 strengthened the mandates for self-reporting overpayments. The Self-Disclosure Protocols were updated in April 2013 with some enticements to providers for self-policing the provider’s performance to reimbursement standards by offering a reduction in penalty assessments by one-half the amount allowed by statute. The Self-Disclosure Protocol can be located at the following link: http://oig.hhs.gov/compliance/self-disclosure-info/files/Provider-Self-Disclosure-Protocol.pdf

The provider should keep in mind the following FACTS about Medicare reimbursement:

1. The Provider is entitled to Medicare funds when eligible beneficiaries receive service that are prescribed by the physician at levels and specificity that meet the Medicare Program requirements.

2. Documentation of the provision of service is the key to determining whether the Provider is entitled.

3. The Provider is not entitled to keep any funds for services to beneficiaries that do not meet eligibility requirements or for services where documentation of services delivered is incomplete, missing or otherwise inaccurate or does not meet a covered level of care.

4. Any amounts that are determined to be ineligible for payment are due back to the Medicare Program. This may be accomplished through bill adjustments, request for
offset or submission of payment by check, credit balance report, or payment plan, if approved.

5. Self-reporting overpayments is required by the Medicare program. The failure to self-report known overpayments is considered fraud against the United States.

When the home health agency receives a denial of payment, the agency should not look at the denial as an exclusive occurrence, but rather should explore whether the agency has any pattern of non-compliance for similar reasons. This requires the agency to examine a set of claims to determine if the occurrence is isolated or not, and if not, to establish the level of overpayment that might exist in other documentation.

The first step in developing a CARE Plan for reducing denial risk is to determine the level of risk and analyze any overpayments that might exit from non-compliance. This involves self-auditing. The sample selection methodology should meet the requirements of the Self-Disclosure Protocol and the related timeframes included in the law. Although the sample selection process is complicated, the provider should minimally examine fifty claims and assure that the selection of claims is random. CMS recommends the use of the free software that is used by the contractors in determining a viable sample – RAT-STATS. This software can be downloaded at the following link: [http://oig.hhs.gov/compliance/rat-stats/index.asp](http://oig.hhs.gov/compliance/rat-stats/index.asp)

If the RAT-STAT software is used to develop the sample, the agency should follow it explicitly. This may require obtaining advice from statisticians and legal counselor before the selection is made. If the agency is simply testing a sample for possible reimbursement risk, the random sample of fifty claims should provide sufficient information to determine if further investigation is necessary.

MJS recommends that the conducting of a sample review for reimbursement compliance be handled at the highest level of confidence under the direction of an appointed compliance officer who reports to the governing board. This officer should not be the administrator or
clinical director or alternates. This is a forerunner to the development of a formal compliance program that has been mandated in the Affordable Care Act but, as yet, unveiled for home health at the present time. Results of the audit should be reported to the governing body.

The denial risk assessment should be a stand-alone feature in the CARE Plan as far as determining the overpayment and the self-disclosure protocols; however, the areas of non-compliance should be addressed in the plan of correction that is developed following the review. The following example for CARE Plan development is provided as a guide in the development of a CARE Plan for reimbursement compliance.

<table>
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<tr>
<th>Deficiency</th>
<th>Corrective Action Plan</th>
<th>Monitoring</th>
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| F2F certifications do not meet Medicare guidelines. | ✓ Conduct sample review of at least 50 F2F certifications.  
✓ Determine specific areas of non-compliance.  
✓ Determine specific physicians involved in the identified areas of non-compliance.  
✓ Re-educate physician and lead staff in his/her practice on areas of deficiency identified.  
✓ If widespread among referring physicians, develop training materials and distribute to all physicians. Use CMS and Palmetto guidelines and examples.  
✓ Target direct re-education to top 10 referring physicians and work in groups of 10 until 100% re-education is achieved.  
✓ Consider training through webinar as option.  
✓ Implement internal QA review of 100% of incoming F2F to resolve ongoing problem with one-to-one analysis.  
✓ Track compliance at first receipt, and number of follow-up contacts to achieve acceptable certification.  
✓ Add F2F acceptability to pre-billing edit and hold billing for any with deficient data | 1. A sample review will establish the areas of most frequent problems and the responsible physicians. The agency will implement a 100% review of all incoming F2F certifications and will continue the intense review until the agency achieves 90% compliance at first receipt review.  
Responsible: QA Nurse Mgr.  
Target Date: December 31, 2013  
2. Pre-billing edit of 100% of F2F certifications will be performed to assure that no claim is filed with a deficient F2F.  
Responsible: Billing Mgr.  
Target Date: Immediate, ongoing  
3. Physician Education Plan for F2F compliance will be implemented for newly referring physician and for physicians with on-going problematic areas identified through # 1 and #2 above.  
Responsible: Marketing/Education Mgr.  
Target Date: October 1, 2013 |
The CARE Plan for reimbursement should be considered for any documentation deficiency resulting in a denial of payment. Blank forms have been provided in the handouts.

MJS has provided an Audit Tool that is designed to capture record compliance for most of the areas of deficiency cited in external reviews. The audit tool may be completed in sections or in its entirety based upon the identified areas of deficient practice.

Review the Audit Tool.
Reference for Reimbursement Compliance

Medicare Benefit Policy Manual Chapter 7, Home Health Services


Medicare Claims Processing Manual, Chapter 10, Home Health Agency Billing


Local Coverage Determinations