



56th Annual Meeting
Thursday, August 28, 2025
1:30pm-2:30pm

5b. Audit Proof Your Documentation

Presented by:

Melinda A. Gaboury, COS-C, CEO,
Healthcare Provider Solutions, Inc. (HPS)

Victoria Barron, MBA, BSN, RN, COS-C, Clinical Consultant, Healthcare
Provider Solutions, Inc. (HPS)

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Audit Proof Your Documentation

Melinda Gaboury, CEO
Victoria Barron, Clinical Consultant

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1



Melinda A. Gaboury, COS-C
 Chief Executive Officer

Melinda A. Gaboury, with more than 33 years in home care, has over 23 years of executive speaking and educating experience, including extensive day to day interaction with home care and hospice professionals. She routinely conducts Home Care and Hospice Reimbursement Workshops and speaks at state association meetings throughout the country. Melinda has profound experience in Medicare PDGM training, billing, collections, case-mix calculations, chart reviews and due diligence. UPIC, RA, ADR & TPE appeals with all Medicare MACs have become the forefront of Melinda's current impact on the industry. She is currently serving as Chair of the The Alliance/HHFMA Advisory Board and Work Group and is serving on the board of the Home Care Association of Florida and the Tennessee Association for Home Care. Melinda is also the author of the Home Health OASIS Guide to OASIS-E1 and Home Health Billing Answers, 2025.

2



Victoria Barron, MBA, BSN, RN, COS-C
Clinical Consultant

Victoria Barron is a Registered Nurse who joined Healthcare Provider Solutions in December 2021 as a Clinical Consultant. As part of the HPS clinical consulting team, Victoria provides support and solutions to home health and hospice agencies nationally to achieve regulatory compliance.

With more than 40 years of nursing and healthcare experience, the majority of Victoria's career has been in the home services arena including home health, hospice, home care, and home infusion where she has served in various roles.

Victoria is a licensed Multistate Registered Nurse and is a CHAP and ACHC Certified Home Health and Hospice Consultant.

3

Learning Objectives:

- Discuss the types of medical reviews impacting hospices.
- Describe the Medicare appeal levels of review.
- Complete documentation following regulatory guidelines.
- Prepare ADRs and appeals that support regulatory requirements are met.



4

Medical Review

- Medicare contractors (MAC), Palmetto GBA, NGS and CGS, operate the medical review program to prevent improper payments and protect the Medicare Trust Fund.
- Medical reviews involve the collection and clinical review of medical records and related information to ensure that payment is made only for services that meet all Medicare coverage, coding, billing and medical necessity requirements.
- A Medicare contractor may use any necessary information to make a claim review determination, including any documentation submitted.
- CMS often focuses on patients with a long length of stay and non-cancerous diagnoses.

Consequences of failure to meet all regulatory requirements

- Claim denial resulting in CMS recouping all money that has been paid to the agency for that claim period. (Claim period = 30 days of service)
 - Lose billing privileges
 - Lose Medicare license
 - Close hospice agency
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5

Levels of Medical Review

- **Post-payment Additional Development Requests (ADR) by Medicare MAC**
 - **Recovery Audit Contractor (RAC)**
 - **Unified Program Integrity Contractor (UPIC)**
 - **Supplemental Medical Review Contractor (SMRC)**
 - **Targeted Probe & Educate (TPE)**
 - **Office of Inspector General (OIG)**
 - **Provisional Period of Enhanced Oversight (PPEO)**
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6

Medical Review Appeals



7

Medical Review Appeal Levels



Five levels of appeals for all claim denials

- **1st Level – Redetermination**
- **2nd Level – Reconsideration**
- **3rd Level – Administrative Law Judge**
- **4th Level – Department of Appeals Board (DAB)**
- **5th Level – Federal Court Review**

8

Medical Review Appeal Levels

1st Level – Redetermination

- Time limit for filing electronically/portal/fax: **120 days** from the receipt of the notice of initial determination. (Date noted on results letter)
 - Appeal the specific reason for the claim denial that is limited to the denied claim dates.
 - Technical denials may not be possible to appeal – Examples:
 - Late F2F
 - Absence of a F2F
 - Untimely verbal or written certifications
 - Untimely signatures on the Hospice Benefit Election Statement
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9

Medical Review Appeal Levels

1st Level – Redetermination

- MAC has 60 days to make the redetermination decision and send a letter to the agency with the results of the review.
 - Unfavorable decisions may result in an overpayment for which the agency will receive a Demand Letter with the amount due in 30 days.
 - Read letter carefully regarding overpayment amounts.
 - Possible to stop recoupment by submitting the appeal within 30 days of the Demand Letter.
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10

Overpayment Demand Letters- 1st Level of Appeal

- Agency receives notification by first class mail of overpayment determination. (Letter date is the determination date)
 - Day 1-15: May submit a rebuttal request within 15 days of the date on the demand letter.
 - Day 16-30 and 31-40: Can request a redetermination and potentially prevent any recoupment from occurring on day 41.
 - Day 41: Recoupment begins unless a request for redetermination has been submitted. MAC shall continue to stop recoupment on or after day 41 from the demand letter date when the appeal request is received and validated.
 - Please note that interest will continue to accrue during this period.
 - If unfavorable, recoupment begins on day 76 of the demand letter date.
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11

Medical Review Appeal Levels

2nd Level of Appeal – Reconsideration

- Appeal is reviewed by a Qualified Independent Contractor (QIC)
 - Consists of a panel of physicians and other healthcare professionals
 - QIC will obtain a copy of the redetermination decision and medical record
 - File a request within 180 days of the receipt of the redetermination decision.
 - May use CMS-20033 form to request the reconsideration appeal
 - Read letter carefully to ensure how to submit the appeal and where to mail it. Appeals have been dismissed due to not sending to the right address of the QIC.
 - QIC has 60 days to determine a decision.
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12

Overpayment Demand Letters- 2nd Level of Appeal

- May receive a Reconsideration Revised Overpayment Demand Letter on open balances only with 30 calendar days from the date of the appeal decision.
 - Day 30 (following reconsideration decision): Provider must either pay the full amount of the overpayment or request for and Extended Repayment Schedule (ERS) to avoid recoupment.
 - Day 60 (following reconsideration decision): Recoupment continues until the debt is fully paid.
 - Recoupment does not cease based on an appeal to the Administrative Law Judge.
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13

Medical Review Appeal Levels

3rd Level of Appeal – Administrative Law Judge (ALJ)

- Administrative Law Judge is an adjudicator employed by the Department of Health & Human Services (HHS), Office of Medicare Hearings and Appeals (OHMA)
 - File a request for a hearing before an ALJ within 60 days after the receipt of the QIC's reconsideration decision. Must have at least \$190 in controversy to file.
 - File a written request using the CMS form OMHA-100 or a written request that includes the:
 - ✓ Name and address of the beneficiary including their Medicare number
 - ✓ Name and address of appellant (hospice agency)
 - ✓ Control number assigned by the QIC
 - ✓ Dates of service
 - ✓ Reason the appellant disagrees with the QIC's reconsideration
 - ✓ A statement of any additional evidence to be submitted and the date it will be submitted.
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14

Medical Review Appeal Levels

3rd Level of Appeal – Administrative Law Judge (ALJ)

- Send a copy of the request for the hearing to other parties such as the beneficiary or the beneficiary's estate. **Failure to send a copy of the request may result in the hearing request to be vacated and dismissed.**
 - Recommend sending certified mail and retain a copy of the mailing notice to include in the request.
 - Receive a Notice of Hearing from the court assigned to hear the appeal with the date, time and name of the ALJ. Ensure all parties are available the date and time assigned. May request to change the date by immediately notifying the court.
 - All hearings are held by telephone.
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15

Medical Review Appeal Levels

3rd Level of Appeal – Administrative Law Judge (ALJ) (cont.)

- CMS or its contractors may become a party to, or participate in, an ALJ hearing after notifying all parties to the hearing.
 - Receive a Notice of Decision letter from the ALJ
 - Depending on the outcome you may receive a Revised Overpayment Letter
 - **Be ready to defend your clinician's documentation to support overturning the claim!!**
 - **Prepare testimony that tells the patient's story and paints a picture of decline over time to support a six month or less prognosis.**
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16

Best Practices for ADRs

- Read letters in their entirety and respond timely to all filing deadlines
 - Ensure all requested documentation in the ADR letter is submitted. **Failure to submit requested documentation may result in a claim denial.**
 - Organize the medical record in topic and date sequence
 - Group visit notes by disciplines
 - Prepare a Table of Contents
 - Include a cover letter outlining why the documentation supports the patient is eligible for hospice with a six month or less prognosis.
 - May include orders, visit notes, certifications from previous benefit periods to further support changes in the patient's condition.
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17

Medical Review Appeal Levels

4th Level – Department of Appeals Board (DAB)/Medicare Appeals Council

- 60 days from the receipt of the ALJ decision to file an appeal request

5th Level – Federal Court Review

- 60 days from the receipt of the Council's decision to file an appeal request
- Amount in controversy must be a minimum of \$1900

<https://www.cms.gov/medicare/appeals-grievances/fee-for-service>

18

Top Palmetto GBA Medical Review Denial Reasons and How to Avoid Them

19

Palmetto GBA Medical Review Denial Reasons– January through March 2025

- | | |
|---|---|
| 1. Not hospice appropriate | 6. No certification for dates billed |
| 2. Requested records not submitted | 7. No Valid Election Statement Submitted |
| 3. Election statement invalid – does not meet regulatory requirements | 8. Physician Narrative Statement Not Present or Not Valid (CTI) |
| 4. F2F Encounter requirements not met | 9. Initial Certification Untimely |
| 5. No Plan of Care submitted | 10. Untimely recertification(s) |
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20

Medical Review Denials

- Regardless of the reason you are selected for TPE, PPEO, SMRC, UPIC, or CERT **all regulatory requirements for payment** are reviewed and **MUST** be met for the claim to be allowed.
 - Claims denied with technical errors and the terminal prognosis not supported are difficult to overturn with appeals.
 - The medical reviewer only has up to a 4-week snapshot of the patient's terminal condition that will likely include on average 4 nursing visits, 1-2 spiritual/psychosocial visits and 2-3 IDG meeting notes.
 - Documentation for both persistent & new symptoms **MUST be supported every visit** to avoid denials under medical review.
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21

Eligibility

- Document the history, progression of the illness/disease, recent changes, exacerbation of symptoms, comorbidities, secondary conditions, variables that are measurable: labs, PPS, KPS, FAST scale for Alzheimer's patients, weight loss, BMI, percentage of meals eaten, vital signs, IDG meeting notes. (Request records).
 - Address frequency of symptom management scheduled and PRN medication administration.
 - Support weight loss with weights, MACs, noting percentage of weight loss. IF unable to obtain weights/MACs, describe physical changes that support progressive weight loss.
 - Ensure documentation is patient specific.
 - Perform clinical audits with focus on determining eligibility in clinical documentation.
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22

Eligibility and Other Documentation Tips

- Include assessment findings that support the 6 month or less prognosis, downward trajectory, decline in the narrative statement. It is not necessary to reiterate normal findings.
- Avoid terms such as chronic, stable, unchanged, at baseline.
- Address ongoing interventions that are required to manage symptoms. Ex. Pain rated 0/10 however patient requires scheduled Fentanyl patch 25 mcg patch transdermal q72 hours and Tramadol 50 mg PO q 6 hours prn for pain. How frequently is PRN medication being administered?
- E-signatures or handwritten signatures should include the name, credentials and date.
- Do not copy and paste.

23

Election Statement

-Model Example of Hospice Election Statement

Patient Name: _____
Hospice Agency Name: _____
Hospice Election
I, _____ (Patient Name) choose to elect the Medicare hospice benefit and receive Hospice services from _____ (Name of Hospice Agency) to begin on _____ (Start of Care Date).
(Note: The start of care date, also known as the effective date of the election, may be the first day of hospice care or a later date, but may be no earlier than the date of the election statement. An individual may not designate an effective date that is retroactive.)
Right to choose an attending physician
• I understand that I have a right to choose my attending physician to oversee my care. • My attending physician will work in collaboration with the hospice agency to provide care related to my terminal illness and related conditions.
☐ I do not wish to choose an attending physician. ☐ I acknowledge that my choice for an attending physician is: _____ (Please provide any information that will uniquely identify your attending physician choice.)
Physician Full Name: _____
Hospice Philosophy and Coverage of Hospice Care
By electing hospice care under the Medicare hospice benefit, I acknowledge that:
• I was given an explanation and have a full understanding of the purpose of hospice care including that the nature of hospice care is to relieve pain and other symptoms related to my terminal illness and related conditions and such care will not be directed toward cure. The focus of hospice care is to provide comfort and support to both me and my family/caregivers. • I was provided information on what items, services, and drugs the hospice is to cover and furnish upon my election to receive hospice care. • I was provided with information about potential cost-sharing for certain hospice services, if applicable. • I understand that by electing hospice care under the Medicare hospice benefit, I waive (give up) the right to Medicare payments for items, services, and drugs related to my terminal illness and related conditions. This means that while this election is in force, Medicare will make payments for care related to my terminal illness and related conditions only to the designated hospice and attending physician that I have selected. • I understand that items, services, and drugs unrelated to my terminal illness and related conditions are exceptional and unusual, and in general, the hospice will be providing virtually all of my care while I am under a hospice election. The items, services, and drugs determined to be unrelated to my terminal illness and related conditions will continue to be eligible for coverage by Medicare under separate benefits.

Last updated: March 2024

Model Example of Hospice Election Statement

Right to Request "Patient Notification of Hospice Non-Covered Items, Services, and Drugs"
• As a Medicare beneficiary who elects to receive hospice care, you have the right to request at any time, in writing, the "Patient Notification of Hospice Non-Covered Items, Services, and Drugs" addendum that lists conditions, items, services, and drugs that the hospice has determined to be unrelated to your terminal illness and related conditions, and that will not be covered by the hospice. • If I request this form within the first 5 days of the election start date, the hospice must furnish the written addendum within 5 days of the request date. If I request this form during the course of hospice care (that is, after the first 5 days of the hospice election start date), the hospice must furnish this written addendum within 3 days of the request date.
Beneficiary and Family-Centered Care Quality Organization (BFCC-QIO)
As a Medicare hospice beneficiary, you have the right to contact the Beneficiary and Family-Centered Care Quality Organization (BFCC-QIO) to request Immediate Advocacy if you disagree with any of the hospice's determinations. The BFCC-QIO that services your area is:
BFCC-QIO Name: _____
BFCC-QIO Phone Number or Website: _____
Signature of Beneficiary: _____
Signature of Beneficiary Representative (if beneficiary is unable to sign): _____
Date Signed: _____

Complete at time of election and before patient/representative sign form.

Last updated: March 2024

24

Addendum Statement

—Model Example of "Patient Notification of Hospice Non-Covered Items, Services, and Drugs"

Patient Name: _____

Patient MRN: _____

Hospice Agency Name: _____ Date Furnished: _____

Ensure the DATE FURNISHED is noted on the form.

Purpose of Issuing this Notification
The purpose of this addendum is to notify the requesting Medicare beneficiary (or beneficiary representative), in writing, of those conditions, items, services, and drugs not covered by the hospice because the hospice has determined they are unrelated to your terminal illness and related conditions. If you request this notification within the first 5 days of the election start date, the hospice must furnish the written addendum within 5 days of the request date. If you request this notification during the course of hospice care (that is, after the first 5 days of the hospice election start date), the hospice must furnish this written addendum within 3 days of the request date.

Diagnoses Related to Terminal Illness and Related Conditions

1.	5.
2.	6.
3.	7.
4.	8.

Diagnoses Unrelated to Terminal Illness and Related Conditions

1.	5.
2.	6.
3.	7.
4.	8.

Items, Services, and Drugs Determined by Hospice to be Unrelated to Your Terminal Illness and Related Conditions (these items, services, and drugs will not be covered under the hospice benefit):

Items/Services/Drugs	Reason for Non-coverage

Note: The hospice makes the decision as to whether conditions, items, services, and drugs are related for each patient. As the beneficiary (or beneficiary representative), you should share this fact and clinical explanation with other healthcare providers from which you seek items, services, or drugs, unrelated to your terminal illness and related conditions to assist in making treatment decisions. The hospice should provide its reasons for non-coverage in language that you (or your representative) understand.

Right to Immediate Advocacy
As a Medicare beneficiary, you have the right to contact the Medicare Beneficiary and Family Centered Care- Quality Improvement Organization (BFCC-QIO) to request for Immediate Advocacy if you (or your representative) disagree with the decision of the hospice agency on items not covered because the hospice has determined they are unrelated to your terminal illness and related conditions.

Updated March 2024

—Model Example of "Patient Notification of Hospice Non-Covered Items, Services, and Drugs"

Please visit this website to find the BFCC-QIO for your area: <https://goccare.org/locate-your-qio> or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Note: The "date furnished" is defined as when the beneficiary (or representative) receives an addendum within 3 or 5 days from their request and not the date of the signature.

Signing this notification (or its updates) is only acknowledgement of receipt of this notification (or its updates) and does not constitute your agreement with the hospice's determinations.

Signature of Beneficiary: _____

Signature of Beneficiary Representative (if beneficiary is unable to sign): _____

Date Signed: _____

Updated March 2024

25

Certification of Terminal Illness

Timeliness:

- Certification is required to be obtained within 15 days BEFORE the start of a benefit period and within 2 days after the start of the benefit period.
- Document verbal certification of written cannot be obtained timely.

Physician's Brief Narrative Statement:

- MUST include patient specific data to support a 6 month or less prognosis. Qualify and quantify information.

26

Tips to Avoid Common CTI Issues

- The hospice medical director and attending physician (if applicable) must sign the initial CTI.
- The physician's brief narrative statement is required.
- The physician narrative must include the statement attesting that it was composed by the physician.
- Verbal CTI should be obtained if needed for timeliness.
- Ensure signatures are legible – print or type the name below the signature.
- Ensure the physician dates their signature.
- Ensure dates of certification period are included on the CTI. (MM/DD/YYYY-MM/DD/YYYY)

<https://api-prod.palmettogba.com/h/elearn/hospicephysiciancertification/story.html>

27

Face to Face Encounters

- Ensure a F2F encounter is performed within 30 days of the start of the 3rd and all subsequent benefit periods. (May occur on the first day of the benefit period.)
 - Ensure the F2F encounter is documented.
 - Ensure the physician certifies the patient AFTER the F2F encounter to support the findings of the F2F encounter were used in determining ongoing eligibility.
 - Certifying physician attestation must attest that the certifying physician performed the F2F encounter and used the findings from the encounter to determine eligibility.
 - Non-certifying physicians must attest that the non-certifying physician performed the F2F encounter and provided the findings from the encounter to the certifying physician to determine ongoing eligibility.
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28

CTI- Brief Narrative

Example: Certification of Terminal Illness Brief Narrative

I certify that John Doe is terminally ill with a life expectancy of 6 months or less if the terminal illness runs its normal course. Certification period dates: 1/1/2025 to 3/31/2025

Brief narrative statement: (Review the individual's clinical circumstances and synthesize the medical information to provide clinical justification for admission to the hospice services) 78 year old male with a diagnosis of stage 4 lung cancer. Completed three rounds of chemotherapy, but cancer has metastasized to the liver and bone. Patient no longer wants to continue chemotherapy and states he wants comfort measures only. Increased dyspnea and pain over past 2 weeks. Is now oxygen dependent with 2LNC and requires morphine every 6 hours for bone pain and shortness of breath.

I certify that John Doe is terminally ill with a life expectancy of 6 months or less if the terminal illness runs its normal course. Certification period dates: 1/1/2025 to 3/31/2025

Physician (printed Name): Dr. Marcus Welby Physician
(Signature): Dr. Marcus Welby Date: 1/1/2025

29

Best Practices for Appeals

- Only a single 30-day claim period is appealed even if multiple claims were requested initially.
 - Write a cover letter that includes the reason(s) you disagree with the denial decision. Include additional information supporting why the claim decision should be overturned.
 - Include Appeal Numbers and/or Control Numbers in the claim letter.
 - May include orders, visit notes, certifications not previously sent for benefit periods prior to the claim dates that further support changes in the patient's condition.
 - New documentation can only be submitted in the 1st and 2nd levels of appeals.
 - Crucial to include hospital or physician records to support the terminal diagnosis and prognosis.
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30

Medical Reviewers

Do not know
your patients

Do not know
your software or
documentation
system

Do not attend
your IDG
meetings

May have never
worked in hospice
care!

31

References and Resources

- <https://www.cms.gov/medicare/coding-billing/medicare-administrative-contractors-macs/who-are-macs>
- <https://www.hhs.gov/about/agencies/omha/filing-an-appeal/forms/index.html>
- <https://www.cms.gov/medicare/appeals-grievances/fee-for-service>
- <https://www.cms.gov/medicare/appeals-grievances/fee-for-service/first-level-appeal-redetermination-medicare-contractor>
- <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c09.pdf>
- <https://www.cms.gov/files/document/mln7867599-period-enhanced-oversight-new-hospices-arizona-california-nevada-texas.pdf>
- <https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=33393>
- <https://www.palmettogba.com/HHH/LCD>
- <https://palmettogba.com/jmh/hh/did/kh5dq3i1h3>
- <https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/se1628.pdf>

32



33



Have any questions?
Scan the QR Code to
schedule a call!

***Thank You for
Participating!***

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34