
**Administrator Program**
Wednesday, November 19, 2025
10:45am-11:45am

# H3. Hospice Audits and Documentation

Presented by:

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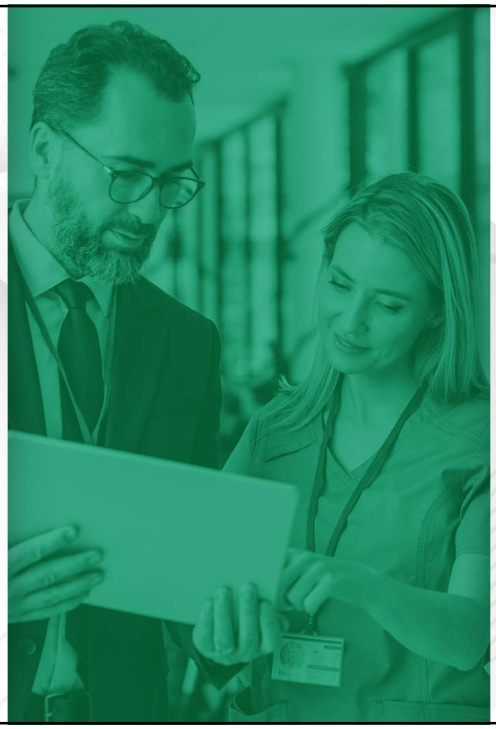
# Hospice Audits and Documentation: TPE, CERT, SMRC, UPIC, and PPEO



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**Victoria Barron**
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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.

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# Medical Review

- The Medicare contractors (MACs), 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 certification
- Close hospice agency

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# Types of Medical Review

- **Single claim Additional Documentation Requests (ADR) by Medicare MAC (may be pre or post payment)**
- **Recovery Audit Contractor (RAC) -** Post Payment ADRs - Cotiviti– all HH/H MACs: J6, J15, JK and JM. (previously Performant)
- **Unified Program Integrity Contractor (UPIC) –** Pre or post payment ADRs. Qlarent, Safeguard Services LLC, CoventBridge Group – based on geographic location.
- **Supplemental Medical Review Contractor (SMRC) –** Noridian – post-payment ADRs
- **Targeted Probe & Educate (TPE) –** MACs based on geographic location; pre-payment ADRs
- **Office of Inspector General (OIG) audits –** GIP
- **Provisional Period of Enhanced Oversight (PPEO)** – new providers after 7/13/23– pre-payment ADRs – can last 30 days to 1 year.

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# Levels of Medical Review

What does a **Recovery Audit Contractor (RAC)** do?

- ✓ RAC's review claims on a post-payment basis. The RAC's detect and correct past improper payments so that CMS and Carriers, FIs, and MACs can implement actions that will prevent future improper payments.
- ✓ Current audit activity includes RACs for GIP and Continuous Level of Care

What does a **Unified Program Integrity Contactor (UPIC)** do?

UPICs perform fraud, waste, and abuse detection, deterrence and prevention activities for Medicare and Medicaid claims processed in the United States. Specifically, the UPIC's perform integrity related activities associated with

- ✓ Medicare Part A & B, Durable Medical Equipment (DME),
- ✓ Home Health and Hospice (HH+H), Medicaid, and
- ✓ The Medicare-Medicaid data match program (Medi-Medi).

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# Levels of Medical Review

What does a **Supplemental Medical Review Contractor (SMRC)** do?

- The Centers for Medicare & Medicaid Services (CMS) contracts with a Supplemental Medical Review Contractor (SMRC) to help lower improper payment rates and protect the Medicare Trust Fund.
- The SMRC conducts nationwide medical reviews of Medicaid, Medicare Part A/B, and DMEPOS claims to determine whether claims follow coverage, coding, payment, and billing requirements.
- The focus of the medical reviews may include vulnerabilities identified by CMS data analysis, the Comprehensive Error Rate Testing (CERT) program, professional organizations, and Federal oversight agencies.
- At the request of CMS, the SMRC may also carry out other special projects to protect the Medicare Trust Fund.

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## Levels of Medical Review

What does the **Office of Inspector General (OIG)** do?

The Medicare hospice program is an important benefit for beneficiaries and their families at the end of life. However, OIG and others have identified vulnerabilities in payment, compliance, and oversight as well as quality-of-care concerns, which can have significant consequences both for beneficiaries and for the program. We will summarize OIG evaluations, audits, and investigative work on Medicare hospices and highlight key recommendations for protecting beneficiaries and improving the program.

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## Levels of Medical Review

**Targeted Probe and Educate (TPE)**

- Goal of TPE is not just to identify errors, but also to educate providers on how to correct them through education calls.
- Selected for TPE based on data analysis from claims
  - Providers and suppliers who have a high claim error rates or unusual billing practices, and
  - Items and services that have high national error rates and are a financial risk to Medicare.
  - Common Edit Reasons: Long Lengths of Stay, Q-Codes such as Q5002 and Q5003
  - Can be MAC specific

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## Targeted Probe & Educate

- The Medicare Contractor (MAC) will review 20-40 claims and supporting medical records (ADRs)
- May have up to 3 rounds of review.
- If compliant, you will not be reviewed again for at least 1 year on the same topic/edit reason.
- 45-day period to make changes and improve
- Education session for claim denials during a round when errors that can be easily resolved are identified.
- If 3 rounds and an unacceptable denial rate still results, the agency would like be referred for further Federal Review. (SMRC)

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## Targeted Probe & Educate - Process

- You will receive a letter of notification informing you that you have been selected for Targeted Probe & Educate with the edit reason you were selected based on the data analysis. **(Round 1 – initial probe)**
- You will then begin receiving Additional Documentation Requests (ADRs) separate from the notification letter. A minimum of 20 and a maximum of 40 claims will be requested for each round.
- At the conclusion of each round, providers will receive a letter detailing the results of the reviews and offering a 1-on-1 education session. Call usually limited to 1 hour. Read the letter in its entirety for important information regarding additional rounds of review and the appeals process
- During the education session, the MAC will educate the provider regarding claims with errors representative of those identified during review.

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## Targeted Probe & Educate – Error Percentages


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## Targeted Probe & Educate - Process

| Round 2 | Round 3 | CMS Referral |
|---|---|---|
| • Begins no sooner than 45-56 days after the education call<br>• 20-40 ADRs selected<br>• Review Results Letter<br>• 1-on-1education call | • Begins no sooner than 45-56 days after the education call<br>• 20-40 ADRs selected<br>• Review Results Letter<br>• 1-on-1education call<br>• Referral (if applicable) | • Referral to UPIC, RAC, SMRC<br>• 100% prepayment review<br>• Extrapolation |

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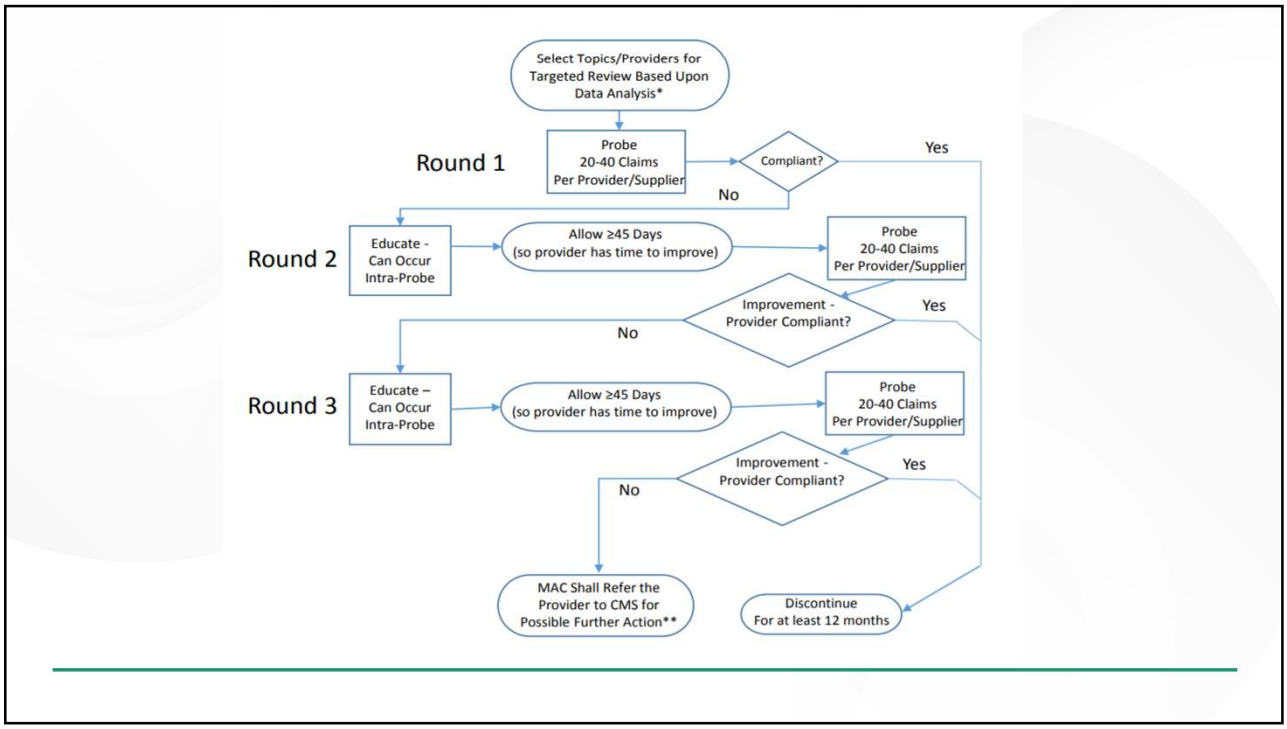


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## Provisional Period of Enhanced Oversight (PPEO)

- CMS has placed newly enrolled hospices located in Arizona, California, Nevada and Texas in a period of enhanced oversight.
- Goal is to reduce fraud, waste and abuse.
- Includes medical review such as prepayment review.
- For the period of enhanced oversight, new hospices include those:
  - ✓ Newly enrolled in the Medicare Program as of July 13, 2023.
  - ✓ Submitting a change of ownership (CHOW) that meets all the regulatory requirements under 42 CFR 489.18
  - ✓ Hospices undergoing a 100% ownership change that doesn't fall under 42 DVF 489.18
  - ✓ Reactivating after being in a deactivated status

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# Medical Review Denials & Appeals

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## Medical Review Denials

**Technical components**

- Technical Physician Certifications
- Beneficiary election statements
- Election Statement Addendums

**Eligibility components**

- Medicare coverage guidelines
- Medical necessity
- Documentation supports the services billed

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## Overpayment Demand Letters following Denial of Initial Post-Payment ADR

A MAC demand letter includes this information:

- That we made an overpayment
- How we calculated the overpayment
- Name and MBI of the patient involved
- Dates and types of the services for which we overpaid
- How interest will accrue, and the interest rate (if the overpayment isn't fully repaid within 30 days)

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## Overpayment Demand Letters following Denial of Initial Post-Payment ADR

A MAC demand letter includes this information: (continued)

- Extended repayment schedule (ERS)
- The recoupment process and options (for example, when recoupment starts, the ability to request immediate recoupment, the impact of filing an appeal on recoupment)
- Rebuttal rights (if applicable)
- Administrative appeal rights
- Instructions to the Medicaid State Agency to withhold the federal share of any Medicaid payments until it recoups the full amount owed to Medicare (if applicable)

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## When Overpayment Demand Letter is Received

The agency may:

- Make an immediate payment
- Request immediate recoupment
- Submit a rebuttal
- Appeal the overpayment by requesting a redetermination
- Request an ERS (extended repayment schedule)

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## Rebuttals

- Must be submitted within 15 calendar days from the MAC's demand letter.
- Must explain and provide evidence why the MAC should not recoup the payment.
- Rebuttals do not stop recoupment activities.

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# Medical Review Appeal Levels


**Five levels of appeals for all claim denials**

- **1st Level – 935 Redetermination** (MAC)
- **2nd Level – Reconsideration** (QIC – varies by jurisdiction).
- **3rd Level – Administrative Law Judge**
- **4th Level – Department of Appeals Board (DAB)**
- **5th Level – Federal Court Review**

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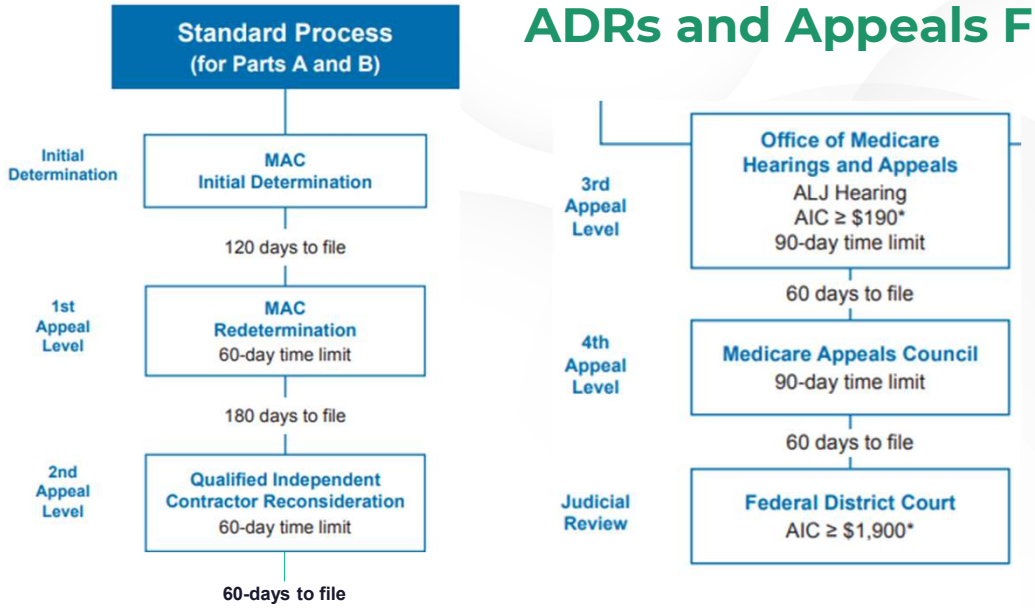
# ADRs and Appeals Flow

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## 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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## Medical Review Appeal Levels

**1st Level – Redetermination (cont.)**

- 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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# 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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# 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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## 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 be result in the hearing request being 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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## Medical Review Appeal Levels

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

- 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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# 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

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# Best Practices for ADRs

- Read letters in their entirety and respond timely to all filing deadlines
- Check your MAC portal DAILY for new ADRs and ADR decisions.
- 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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## 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 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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## 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!

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## Medical Review Denials

- Regardless of the reason you are selected for TPE or any other medical review **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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## MAC Specific Denials

**Palmetto GBA (April-June 2025)**

- Auto denial - Records not submitted
- Not hospice appropriate
- No Plan of Care Submitted
- Hospice Continuous Care Hours Reduction
- GIP services not reasonable/necessary
- Untimely CTI

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## Top Medical Review Denial Reasons

- **Documentation Does Not Support a Terminal Prognosis of Six Months or Less.**
- **The Hospice Election Statement is invalid because it Does Not meet the Statutory/Regulatory Requirements.**
- **The physician narrative statement was not present or was invalid.**
- **Face-to-Face Requirements Not Met.**
- **The General Inpatient Level of Care – Not Reasonable or Necessary.**

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## Tips to Avoid Denials

- Obtain and review supporting medical records prior to admission.
- Perform QAPI clinical audits on records including certifications of terminal illness narrative statements, IDG meeting notes, visit notes and orders to ensure documentation clearly supports eligibility.
- Establish a process to ensure Face to Face encounters are performed timely.
- Review GIP documentation daily while the patient is on GIP level of care.
- Review election statements prior to leaving patient at time of signing to ensure all required elements are noted.
- Ensure election/addendum forms include all required language.

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## Remember……

### 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 certification
- Close hospice agency

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## 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://www.cms.gov/files/document/medicare-overpayments.pdf

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QUESTIONS?

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Have any questions?
Scan the QR Code to schedule a call!
Thank You for Participating!
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