HUSCH BLACKWELL

Hospice Insights: The Law and Beyond

Episode 16: COVID-19 Hasn't Interrupted Everything: Certain Hospice Audit Activity Continues Despite Public Health Emergency

July 22, 2020

Speaker	Statement
Meg Pekarske	Hello! Welcome to "Hospice Insights: The Law and Beyond," where we connect you to what matters in the ever-changing world of hospice and palliative care. "COVID-19 Hasn't Interrupted Everything: Certain Hospice Audit Activity Continues Despite Public Health Emergency." COVID-19 threw a wrench into certain audit activity, but the machine rumbles on. In today's episode, Meg, Erin and Bryan discuss the certain state of hospice audits, including TPE, UPIC and OIG audits and the high number of technical denials hospices have seen lately. The team will highlight the top five most frequently cited technical denials in 2020 and provide some first-hand insight into CMS' QIC telephone discussion demonstration. Bryan, Erin welcome. Thanks for joining me for today's podcast.
Bryan Nowicki	It's great to be here, Meg.
Erin Burns	Happy to be here.
Meg Pekarske	So Erin, let's start with you giving us the lay of the land. I think that the COVID world has changed, obviously, many things and I think that audit activity is one of them and some things have stopped but other things have not, so why don't you give our audience the lay of the land as to what's stopped and what hasn't.
Erin Burns	So I'm sure everyone will remember that back in March – I was going to say October, what is time these days? Back in March, a public

Speaker	Statement
	emergency was declared which allowed CMS to issue some waivers related to certain activities, including some audits. So we saw that TPE was suspended, or Targeted Probe and Educate, was suspended, and some other CMS contractor activities. What was *not* specifically stopped was UPICs, or program integrity efforts, and some OIG audits. We also saw that although they were relaxing some of the contractors' deadlines, they didn't relax everything. So there are some appeal deadlines that could be extended and then some of them that couldn't.
Meg Pekarske	So it sounds like, from what I hear you say, if you weren't already in the pipeline, you're not going to get in the pipeline now in COVID. However, if you were in the pipeline and had some appeals, those things were moving along. You might have some wiggle room as to the appeal deadlines and extensions. Can you explain a little bit about some of the extensions we have been able to get for clients?
Erin Burns	Yeah. So we, just to go off of what you said there, you're absolutely correct. From what we have seen, there are no new audits starting. We haven't seen any new record requests. TPE seems to have been actually suspended. But for those that are still in the pipeline or that were in the pipeline before the PHE or the public health emergency was declared, yes, the audits continued to go on. In terms of extensions, what we've been working with some clients to do, you know, when this all started in March, if you had redetermination or reconsideration requests, even a record request that was due, we've been able to kind of get extensions on those deadlines to push them back just a little bit. We've been told, too, that in conversing with some of the contractors that you don't need to request an extension outright, that you should just be able to put it in your cover letter saying this is related to, or this is linked due to COVID. We haven't necessarily done that. We don't necessarily think that you want to just wait and put it in your cover letter. We would kind of recommend some proactive action on either the hospice's part or through counsel to let the hospice know – or to let CMS and your contractor know that you are behind due to staffing or due to some other COVID-related reason.
Meg Pekarske	So Bryan, we don't want to just take, well, but they said, like whatev, whatev, you can get this in and so you didn't want to take that approach, Bryan?
Bryan Nowicki	No, and although Erin's absolutely correct that that's what they said to do, just blow the deadline but tell them later on that you missed it because of COVID. I was too worried, and we as a group were too concerned, that once you missed that deadline, something happens at the contractor to say well, it's day 120 for redetermination or it's day 180 for

Speaker	Statement
	reconsideration. We don't have anything; therefore, I guess they're not appealing. We're going to close the books on this or take some other action, and that's what we didn't want to happen, so our recommendation has been – and this is what we've actually done – is get out in front of that deadline and send them a letter in advance saying by our calculation, our appeal deadline is July 17. We want to let you know in advance that we are appealing, but we're not going to make that July 17 deadline due to COVID. And then once you do get your appeal put together, do as they suggest and include in that appeal letter that, you know, we are submitting this and it was delayed due to COVID, but we understand that you are accepting these appeals nonetheless. And that way, you're giving them a head's up, you're including what they want you to include, and you should be good for getting this in and it will be considered timely. And as of now, they haven't lifted that exception or that protocol. I'm sure at some point they're going to say, you know, no more late entries. We're not going to accept those anymore. But they haven't signaled when they're going to do that and as of now, you can still get that flexibility on these appeal filing deadlines.
Meg Pekarske	So in terms of – let's talk about the money matters of this equation. If you're in the pipeline, it sounds like it's sort of business as usual. Now, you as a provider might be able to get an extension, but from what I understand, it seems like contractors are meeting their deadlines so things are trucking along at a sort of usual pace, especially some of these UPIC audits we have. Can you tell me a little bit about what kind of monkey wrench that's throwing into people's efforts and business when we're juggling a whole lot of things, and these UPICs can have many millions of dollars at issue? Like what do you do? You get this, you have 30 days to appeal, to halt recoupment and they're saving you millions of dollars, like, what have we done? What can you do? Does this extend to recoupments I guess is my question? Because great if I have a 180-day deadline and I can take more time than that, but the recoupment deadlines are usually more accelerated if you want to halt recoupment. Tell me about those.
Erin Burns	So we unfortunately, although the contractors have been very flexible in terms of appeals deadlines, that doesn't extend to the money. We have tried to contact contractors, especially in some of the, like you mentioned, multi-million dollar cases that we have, to see if they can extend recoupment or delay or hold to recoupment, even though the hospice hasn't had a chance to submit their appeal yet. And the response that we've gotten on that is no, unfortunately. So what we have done is submit kind of like a shell of a request, I guess you can call it, or kind of like a placeholder request within the deadline to submit and to halt recoupment, so within your 30-day window for redetermination, or 60

Speaker	Statement
	days for reconsideration. And you can also supplement that prior to getting a decision, so that's what we have done for some of our clients and so far it has worked. But you want to be sure to submit your supplement as soon as possible, too, to make sure that you don't lose that round of appeal in general.
Bryan Nowicki	Yeah, typically the elements of an appeal are rather simple and they're not complicated, they're not extensive, so to submit a redetermination request, the bare minimum you need is a pretty limited set of information. Now what we typically do, what we always ultimately do, is have a much more robust appeal where we are tackling each and every denial, providing a counter argument for it, submitting documents that support our counter argument. It's a much more involved document because we think that's the best way to get a good result on an appeal. But as Erin said, if you're dealing with them recouping – starting to recoup by shutting off your Medicare payments in 30 days and you can either submit this bare bones redetermination request to halt that, or you have to take the extra time and suffer through some recoupment until you have all your ducks in a row in the more robust response, a number of our clients had said let's submit the placeholder, the bare bones response, and as Erin mentioned, we supplement that afterwards with the more robust submission and you want to make sure those get in there. And the rules allow for supplementing your appeal request, so there's nothing inappropriate about supplementing after the fact. The effect that has on a decision is it gives the auditor or, I'm sorry, the contractor, more time to make the decision, so you're extending out their decision deadline. Typically they have 60 days from the request to issue a redetermination or reconsideration decision. If you submit supplemental material, you're automatically giving them another 14 days. For some clients, that's a good thing, because you're just further extending the amount of time that they are not going to recoup. So we've toyed with ideas of filing a bunch of supplements over time and giving them additional time as we kind of prepare a more complete response. So that's been a strategy we've been able to employ, especially in these times when so many hospices are already under water with work, and to get an audit result or a redetermination decision where they've got to devote physician resources to doing a real robust response. They just don't have the luxury of doing that at this time, and so we've worked through these alternative strategies. And then there's some other case-by-case ones that we go through where we have been able to get additional extensions in unique circumstances. So kind of a default is this bare bones appeal, but given your specific facts, we've been able to find even additional reasons to work with the contractor and with CMS to get further extensions on appeal deadlines and other decision deadlines that have the effect of

Speaker	Statement
	halting recoupment.
Meg Pekarske	Just quick before we leave this subject, when the contractor said no, I can't halt recoupment or delay that, they're saying I don't have the authority to do that, correct? CMS?
Bryan Nowicki	Yeah, well right. And the message we've gotten from them is they've reached out to CMS for direction on this, but they as the contractor don't see themselves as having the authority to make that call unilaterally. They need CMS to approve it. They say they've reached out to CMS and apparently CMS has not green-lighted this kind of blanket stay of all recoupment activity, so we've had to take some of these other actions that Erin and I have described.
Meg Pekarske	So the last type of audit, I think, is probably off many people's radar screen because I think it impacts fewer people, but I think interesting nonetheless, and I'm sure we'll be talking about these in the coming months and probably years to come is these federal OIG audits that we understand are going on in the industry that hospice is an area where they are doing some hospice-specific provider audits. So it will be ABC Hospice and we're aware of a number of other hospices and so it's a hospice project, which is different than the work plan-type initiatives that are focused on the industry. This is going to be focused on providers. Now these started well before COVID and during COVID, they have, I think, continued and we're working on a number of these. And so I think that it's interesting that those are, as we said in the opening, rumbling along and sort of with, essentially, no consideration specifically as it relates to COVID. And so I don't know if you have other thoughts you wanted to share on that, Bryan. I know you've been heading our efforts on these OIG audits.
Bryan Nowicki	Yeah, and we are aware of, in addition to what OIG does, as you described, the industry-wide group to get the audits to gather information, we're aware of at least two larger projects the OIG is working on in relation to hospice. One is focused on GIP services, the other one is focused on – not focused on GIP, but includes GIP and eligibility for hospice and they're going after particular hospices. These are reports that if OIG stays true to form, they're ultimately going to be published by OIG and could be headline material. And given what we've seen from OIG over the past couple of years, the headlines they're looking for in the hospice industry are not real friendly to hospice providers. So yet the audits that – and we've been involved in a number of these and they have been trudging along. And these are taking quite a long time, months and years, but there's not any kind of delay in that activity. We understand that OIG may be a little more forgiving in terms

Speaker	Statement
	of responding to these reports once they come out, but they are going to come out. It's just a lot of uncertainty regarding when. It could be we'll start seeing these roll out later this year, it could be into next year. The OIG takes its time with some of these audits and I think just for those who are not directly involved with them, you're likely to see over the next couple of years some more headline-grabbing information from OIG that may not portray hospices in a very accurate light. It's another obstacle or another item that hospices are going to have to overcome to really get the word out that they are providing good quality care and they are a very important part of the healthcare delivery system.
Meg Pekarske	Yeah, and so I think going back to something Erin said earlier is, program integrity audits could continue during COVID and while we personally haven't seen new UPIC record request, it's possible. And I think OIG under perhaps the banner of program integrity is saying our audits are continuing onward. You're in the pipeline. I don't know if they started any new selections of hospices. Everything we've been working on has been in the pipeline for a while, but anyway it sounds like there is some relief and flexibility you can get. Probably no new record requests is what I'm hearing from you and Erin, but if you are in the appeal pipeline and you do have challenges from a resources standpoint, there's some flexibility and working with counsel to navigate those waters is probably a good idea. So the next thing I wanted to turn our attention to is, since things in the pipeline are continuing to move, I wanted to get a glimpse from you all about the types of denials that we're seeing. And I think in particular, we've been seeing an uptick in technical denials and so clinical eligibility obviously continues to be an area of focus, but I think in terms of what can we learn from what's going on right now is there's a lot of attention on paperwork and we won't review in this podcast the six conditions of payment as folks already know those, but a lot of those six conditions of payment have to do with paperwork. And so Erin, I wanted you to share some insights you had on these top technical denials that we're seeing. Can you give us a rundown of those?
Erin Burns	Yeah, thanks, Meg. So we're going to a top five technical denials that we've seen so far this year in 2020 which, given the state of COVID and everything, you wouldn't think that we would have a top five, but we do. So clinical eligibility continues to remain an issue. We've seen a lot of GIP audits as well, or GIP patients getting down-coded to reaching home care, so that continues to be an issue. But these technical denials that we're seeing, like Meg said, have a lot to do with crossing your T's and dotting your I's, and it seems to be almost like the contractors are taking – kind of like picking at the hospices or taking cheap shots at them in

Speaker	Statement
	terms of certain issues. So the top five that we have seen, and we'll go into each one a little bit, is narrative sufficiency on certifications, physician or E&M services being denied generally, timeliness of certifications, both initial certifications and recertifications, and then no physician at team or a lack of documentation showing physician involvement, and invalid verbal certifications.
Meg Pekarske	Let's break that down a bit. So this narrative sufficiency, the condition of payment we're dealing with is all certifications have to have a physician narrative. Now there's many components, right? There's the attestation component, there's a signature, but in particular, the narrative sufficiency, so it's not like there is no physician narrative that was composed …
Erin Burns	Correct.
Meg Pekarske	… but there is a subjective determination that this narrative is insufficient and so I think for our listeners, they might think well, of course, if someone wrote the words down, that's going to be insufficient, perhaps. But tell us, because you're really deep into this, tell us the types of things that you're seeing as narrative sufficiency denials and how does that compare to what is, in a different audit, passing muster as sufficient. Can you give us some flavor for that?
Erin Burns	Yeah, so the narrative sufficiency issue is probably by far and away the most common technical denial that we've seen lately, primarily in UPICs, but it has come up in other audits. Here what we're seeing is, in the decision you just get a couple words saying the beneficiary had this symptom and this symptom and there was an appropriate certification, unfortunately, the physician narrative didn't support a terminality or support a six-month prognosis, and that's all they give you. So when we go in and we look at the actual narrative and see, like Meg said, it's not just two lines or two words, it's a substantive paragraph describing this patient's age, diagnosis, morbidity, maybe a PPS score, weight, etc., and that's still being denied. So as Meg said, it's a very subjective standard. All that the regulations require is that it be brief and reflect the clinical circumstances. So that's kind of what we say when we try to fight these denials and in one audit in particular, we saw one type of physician narrative get approved and then others, with very similar facts, very similar patient data included, get denied within the same audit. So it just goes to show how subjective the standard is. And we use that to our advantage when we appealed this to the next contractor to the QIC to say, how can you argue that this one is okay, you know, it includes age, FAST score, recent events and this other one, where Patient B, including the same types of facts, is not sufficient. So this is a very frustrating – to

Speaker	Statement
	me, one of the most frustrating denials that hospices have been getting because it is – what are they looking for if that's not good enough?
Meg Pekarske	And I think that it sidesteps the issue is – so someone could be clinically eligible for hospice, the physician has properly certified them, so there's no dispute about clinical eligibility and that there's no dispute that the physician composed this and wrote this and this is what the physician, he or she, believes to be most relevant and it's reflective of the patient, and that that's not enough and now you're fighting a technical denial. I mean, it really seems, and I hate to use the word unfair, because it's more than just unfair. I think it's unsupported by the law, but it just – I'm very concerned about the morphing of that and this focusing on things that are so subjective. And Bryan, you've heard my rants on this, so I don't know if you have other thoughts you want to share about how we attack those, but I think it is a very troubling development.
Bryan Nowicki	Yeah, and I think the way Erin outlined one of our strategies is a really good one to show the internal inconsistency of the audit and I'm going to speak in a little bit about experiences I have had talking with the QIC reviewers, which I think brings a lot of our frustrations to light. So when we get to that section, I'll go through some of – because we did talk about narratives as part of that, and I can kind of reveal my insight into what the QIC is thinking and how they're addressing these things, which is – there's a light at the end of the tunnel, so let's listen to Erin talk about these technical things, but I'll try to wrap this up with some good news for a change. I'm usually talking about all of the horrible things that can happen with litigation.
Erin Burns	I'll be the bearer of bad news today.
Meg Pekarske	Yes, no, exactly, and someone should not stop listening. Keep listening, slog through our parade of horribles here. So then the second one you ticked off is visits – physician visits – and just to put some color on this, so hospices can bill for physician services and that's – we're not talking about NP services, but physician services, and they have to put those on the claim form and those get billed on the Part A claim, but it's a separate line item. And so, I think historically, we haven't seen the contractors focus on well, this shouldn't have been this E&M code, it should have been this code, but they are looking for evidence of if you put a physician visit on your claim for May 2, they're going to look or know for May 2. Is that right, Erin? Is that what we're seeing is that sometimes people aren't submitting the physician documentation?
Erin Burns	Yeah. We've seen that and a lot of times in those denials, the reviewer will specifically say, like, no evidence of visit on May 2. So then the hospice knows just to submit that visit to make sure to prove that up. But

Speaker	Statement
	there's a lot of times where the reviewers, the auditors, are saying well, because this patient is not clinically eligible, we're also going to deny the physician visits during this claim period. And that is, again, a very frustrating denial, because it's not – that's not how it works. So those physician visits are separately billable, meaning that they are not paid under the per diem that the hospice gets. That is ostensibly being denied. So if you're denying physician visits just for clinical eligibility whether the patient was on hospice or not, they – Medicare would still be responsible for those visits so they shouldn't be lumped in with that denial. And that's essentially the argument we make on appeal. What's even more frustrating is when a client is not getting denied on clinical eligibility, but they're being denied on technical grounds, and they're then also denying the physician visits. Meg mentioned there are a lot of cases where there's no dispute regarding clinical eligibility. We had one patient who was on GIP, died while on GIP, denied it for a physician narrative and then also denied the E&M codes, or the physician visits, so just kind of tacking on things that they shouldn't even be focusing on in the first place that don't get at the heart of the hospice benefit.
Meg Pekarske	Well, and I think that, exactly, the argument on the physician visit is the medical necessity standard for Medicare paying for physician visits isn't did they have a six-month prognosis, but was this service needed? And again, typically, because they're not saying the physician didn't need to go out and see this patient, this patient didn't have symptoms that needed to be managed or getting at the – you know, this code, this E&M code wasn't supported, it's saying well, if they're not hospice eligible, then none of these physicians services are available. Yeah, it's a very compounding problem, but I think as we tick these off, I think maybe a take-away here that you could actually do something about, and we talk about this with folks is, you really need to make sure when you're producing records in an audit that you're looking at your claim form and seeing if you have physician services and then making sure you're pulling those notes, especially if you have a consulting physician arrangement, making sure you get copies of notes for physician services you're billing, because that is going to be just a litmus test is do you have a note? If you don't have a note, I'm not going to pay that. And I think on the narrative sufficient argument, just in terms of if we're trying to say, you know, what is it that you can do about this? I mean, there's some stuff that we can't necessarily – we've got to win these issues from a legal perspective, but I think what can clients and hospices do, the narrative sufficiency, I think, continuing to focus energy on educating our physicians on how incredibly important narratives are. And I would say they are probably the single most important document in terms of

Speaker	Statement
	supporting clinical eligibility in the medical record. Not that all of the other services aren't important, but that the physician is a dot connector and they're having contemporaneous information that supports their clinical determination that the person has a six-month prognosis and I think continuing to focus significant educational activities on physicians and that they understand that. Because I do think if physicians were writing very, very robust narratives, I don't know if we would necessarily see these. I do find it very surprising of – there's a meaty paragraph there and they're still denying it, so I can't necessarily make sense of that, but I think the more we focus physicians on the importance of that document, I think it's better. So then the third one you wanted to talk about was the time.
Erin Burns	Just to comment on that, Meg, even where there is robust paragraphs, sometimes we see them get denied if there are two certifications in a claim period that they're looking at, and those robust paragraphs are very similar. So you want to make sure like the physician, if there's no change and they want to change their narrative to reflect the changes that have been made, because otherwise if it's the same, it's not a far stretch for the reviewer. Hopefully they are reviewing the records and seeing decline or a symptom themselves, but if the narratives for two different benefit periods are the same, it's not a far stretch that they can say well, there's been no decline. So I think that that's important for physicians to recognize too, that you want to kind of change it up, I guess.
Meg Pekarske	And I think to that, and we could do a whole session and we have a multi-part series on physician issues that we're going to be unveiling in our podcast, so I won't take our thunder away from that, but I agree that physicians want to make sure that there isn't an appearance of copying and pasting or, even if it's not copied and pasted, that it's just too similar. And I think feeling comfortable with saying hey, why do I still think this person is eligible even though they haven't had a precipitous decline over the – since the last benefit period – like proactively address those things because ultimately, in three years from now, if the government says well, it's not reasonable for you to have made that clinical determination, you could say well, here's what I said at the time and this is what I was thinking and sure, they didn't have a 20-pound weight loss, but they were still on a terminal trajectory and here's why. So I think feeling comfortable with proactively addressing things that one might see as a weakness or something and sort of being very transparent and address that, as opposed to thinking I'm ignoring that – certain things. So then we get into the timeliness of certifications, and this is just, again, so many things in our conditions of payment that can trip us up because we have the timing of verbal certifications and the written and how far in

Speaker	Statement
	advance the face-to-face can be before the written, and there's lots of timelines that we need to be thinking about. And so what do you mean by timeliness of certification denials? What are you seeing, Erin?
Bryan Nowicki	So we're seeing a lot where the auditor is looking specifically at one – either the initial certification should have been signed and dated or the recertification, so maybe it's past the two-day window. And so – and they're not actively looking for a verbal to shore that up – so if it's five days after the benefit period starts, then they're going to deny that as untimely. And I think that kind of goes into one of the other ones that I mentioned, the verbal certification, so like I said, contractors are not going back into the record to make sure that there was a verbal certification that kind of stopped the clock for the two-day requirement. And the requirement there is that if you can't get this signed, the written, signed certification within the first two days, then you need – I'm sorry, yeah, the first two days – then the signed certification just has to be done prior to submitting the claim, so long as you got a verbal certification or a verbal recertification. We're seeing this issue both in UPICs, but also more recently in the TPE context where someone that we're working with has gotten a lot of denials on their TPE. And here, so their certification may have been signed 5 or 10 days after the benefit period started, but they have a valid verbal certification. They submitted the verbal on a form that says "Verbal Certification Form" has kind of the required elements, of which there are very few, and that is still being denied as an invalid verbal certification. What we've worked with those clients to do is kind of highlight the regulations related to those things. The verbal certification, like I said, has very limited requirements. It just needs to be documented by whoever receives it in the record. It doesn't even need to be on a verbal certification form. Some people do it in a visit note. But I think what's important here is that you have that verbal certification, you have a process for getting that, and you document it appropriately, because if you're getting those late certifications or untimely certification denials, you at least have that verbal certification to back it up.
Meg Pekarske	And just to be clear, that your written certification isn't untimely if you've got a verbal …
Erin Burns	Correct.
Meg Pekarske	I mean, just to – but I think your point is well taken, is the verbal certification, I think, is something a lot of folks rely upon and I think there can be inconsistencies on how, even within an organization, how folks are documenting that. And so we won't go down the rabbit hole of are you getting it from the right physician and the whole attending

Speaker	Statement
	physician and is that matching up on what's on the election form, because that's a whole other line that we've done a podcast on in the past about making sure that you're getting it from the right physicians. But I think that when people have been getting these denials, they've been surprised that staff are not documenting things in a consistent way. And so you've mentioned that folks were sometimes doing it – embedded in a note versus – obviously, ideally, it's best to have it exactly where it's always in this one place, and so right, the whole point of record review is to make it as easy as possible for the reviewer to pay your claim, which is having a system and having forms that clearly document all the elements so people don't have to go searching. Because the government isn't going to connect dots that we haven't easily connected and so I think that you're absolutely right, verbal certifications are incredibly important. And one quick last thing is, and this correlates to the conditions of payment related to care planning, that the care plan has to be reviewed every 14 days and there have been instances where contractors have said I'm not seeing that the physician attended the meeting. They ask for a sign-in sheet that the physician didn't sign and there isn't evidence that they reviewed the care plan and obviously, we've been able to connect some dots in order to defend those, but I think that the point being is, you really need to make sure that you've got physician coverage at your IDT meetings and you need to make sure you understand how people are documenting that involvement. But give us a little more flavor for what you're seeing in the records related to this issue.
Erin Burns	Yeah. So if – a lot of times it seems like if a hospice does sign-in sheets and there's no physician signature on that sign in, they're going to get denied for that. Even though sign-in sheets are not required, that seems to be kind of what contractors expect at this point, and it is a way for hospices to document various team members' involvement in reviewing care plans. So what we're seeing in the way that we're combatting that is to have other sources of communication between IDT members in the record. And so it's important, you know, if they're making orders or they're revising the care plan in any way, to have that documented so that we can prove that they are involved in that process because the regulations don't specify how that review is to happen or how it has to be documented. As I said, sign-in sheets are just one way that people do it. If you are using sign-in sheets, make sure everybody that's at the IDT meeting is signing it. If a physician participates remotely or any kind of other issue arises, document it so that you know what happened that day. We had one instance where a physician had asked or had alerted the hospice that they were going to be there and there was a miscommunication and they didn't have a physician at that team meeting. So that's an issue. But again, the way to combat this is by

Speaker	Statement
	having good records, good processes, following those processes and documenting interactions between team members.
Meg Pekarske	And I think that, as you say, there's no one way to do that, but obviously, starting your IDT meetings with a list of who is present and participating in that meeting, because I think the sign-in sheet sometimes can be a challenge because someone could have been there and they just didn't sign because they were on the phone or whatever that may be, but I think it's having a system, sticking to it, making it very clear. And I think there are oodles of ways that we can demonstrate physician involvement as you said, but again, you want to avoid these denials to begin with because you don't want to end up in a round two of TPE or you don't want to end up in a recoupment situation on a UPIC. It's like let's head these kinds of things off to begin with. And so I want to close with our uplifting story that Bryan has for us as it relates to something that I think has been fairly interesting for us and it's a new thing. Everyone who's listening to this is probably very well aware of the continued backlog at ALJ to get to the administrative law judge for a hearing when you're moving through the appeals process, and so there've been many efforts by CMS to clear the decks of cases and settlement opportunities and whatnot, but an interesting newer development is this CMS QIC demonstration project and Bryan, why don't you explain a bit what that is and then how they've been going for providers and whether or not you think it's fruitful to participate. Because it is – it's not required, it's voluntary.
Bryan Nowicki	Yeah, it is. And for those of you familiar with the appeal process, the QIC is the decision maker at the second stage of appeal, which is called reconsideration. So you've gone through an audit, you've appealed that, you've got the MACS redetermination decision, you still don't like the results, you appeal it to the QIC seeking reconsideration, and the QIC – the qualified independent contractor – is supposed to take an independent view of that, and then they typically, in the ordinary course, would issue a written decision. And if you don't like that, you can go to the ALJ. So these first two levels of appeal that I just described, it's ordinarily all on paper, which is not always the most effective way to communicate about some, what can be some complex issues, even though there could be a rather simple solution. So what one QIC has done, and this is C2C, and this is with the approval of CMS, is they've opened a telephone demonstration project where before they issue a decision, you can volunteer – they will select you as a candidate and you can agree to participate in a phone call with one of the people who will actually be reviewing your appeal and participating in the decision making process, so you don't have to rely just on what's on paper and worry about

Speaker	Statement
	happens to your written submission when you submit it. Who gets it, how does it get pulled apart, is it being interpreted correctly? You actually get to have a phone call with that decision maker and we participated in a number of these calls and leading up to the call, there is some, I wouldn't say intimidating, but maybe some foreboding information that's out there. They give you a notice of the impending call. They say they go claim by claim, so they'll talk – they say they'll talk about these one month at a time and if you, like we did, we had some for over 30 claim periods, a longer length-of-stay patient, or over 20, they will calendar these to last three days, so you're going to be on the phone with the QIC from 9 to 4:00 pm for three days in a row, or so it seems. And that was kind of worrisome at first. You know, how do you prepare your physician to get ready for that? I mean, this is like a whole hearing that's going to take place.
Meg Pekarske	Mm-hmm.
Bryan Nowicki	Well, the further we got into the process, the more we realized that's not really how it happens. In our experience, the calls that we've engaged in are much shorter than that and we haven't had to slot three entire days. I don't think I've had one that's lasted more than hours of the ones that I've done, and this is including our time to participate with the physician who we involve in these to provide additional information. If eligibility is the issue, then we have that physician prepared and ready to go. And what's refreshing about the experience is this communication you have with a reviewer. And when I've done it, it's been a nurse for the QIC who's on the phone and they're pretty open about the idea that they are looking for support for the hospice's conclusions. If the hospice said this patient was eligible and we have certifications, they're going to look for what supports that and their aim is to try to see – try to undo a claimed denial. And they want to – they are essentially, I think, advocating a bit for the hospice through this process. And it's very refreshing to hear that from an auditor or a contractor, I guess, because, as Erin just got done explaining, we're seeing more and more of these auditors get really ticky-tacky on some of these technical denials that are really not consistent with the overall review and what they're seeing. It doesn't mean the patient's not eligible, but they're just looking for ways to deny, and so it's refreshing to have somebody take the opposite approach. It's not only refreshing, I think it's entirely appropriate, given that case we always talk about, Meg, of AseraCare, where the court in AseraCare, this is a hospice False Claims Act case, talked about what kind of documentation needs to be in the record and what is required of that documentation. And the court was very clear that, based upon the regulations, the documentation needs to support what the physician was saying. It doesn't mean to *prove* that the physician appropriately

Speaker	Statement
	certified, it just needs to have some support for that. And so what I found in having these conversations with these QIC nurses is, that's exactly what they're doing. How does the medical record, or *does* the medical record support the physician. Not prove the physician right, but support the physician. And so they've been very helpful in that regard, to go through this process. And they're dealing with both technical issues and clinical eligibility issues. And some of the items that Erin shared with you on these top five technical denials we're getting from auditors and maybe that are reinforced with a MACS, through this telephone demonstration project, I get some insight into how the QIC is looking at this in that context and they're not following in lock step with the auditor or the MACS. Or at a minimum, they may start out that way, but then you can talk through it with them and explain what the regulations require. Because I've had to address this notion that you need a certain certification within two days of admission and all it took was 15-20 seconds of explanation of, well yeah, that's for the verbal, there's really no timeline for the written. It may depend on when you can drop claims and get them paid, but you could get a written certification at any time after the admission, theoretically. And so just having that brief exchange kind of turns the light switch on, and that's a phrase that the nurses I've spoken with have talked about. It's like oh, now I get it. Now I know what your position is, or how I'm misinterpreting that. And the same with the narrative. We've dealt with a number of claims that were denied for narrative insufficiency, narratives that I thought looked very complete and robust. These are some of the better narratives I've seen and the nurses who are reviewing these, they review them and I point out that, look, they denied these narratives from the first half of this month, or this year, but then they're approving all of these for the second after essentially the same. We don't get it, you know, the same in terms of the kind of information. There's really no justification for that inconsistency and the lightbulb goes on and they say, oh I guess you're right, I see that there's – that we can't be inconsistent like that and these are all approvable. And we've been able to sort out issues about the appropriate identification of an attending physician. There were some technical issues that have been raised about well, on this plan of care document, you didn't have the right admission date. Well, you know, who cares? It's a plan of care document. You're going to get the important stuff. If there's a typo about the date of admission, the QIC reviewer that I spoke with said we're not going to get hyper-technical on you like that. And that's the appropriate response because that level of detail, there's no way that can be a condition of payment or that that is material to a payment decision. So it's great to have the QIC take a more practical view of this, consistent with the law, and not just be out there to find ways to pin an overpayment on a hospice. And on the clinical side, I

Speaker	Statement
	found very much the same. They're going through the medical record, looking for the data that supports the certification and it's amazing, when you look at it in that light, how much – how different the medical record can be interpreted. Typically the auditors in my view, they're looking for all the information that is *against* the certification and they'll cherry pick a lot of that information out and they base their decision on that. That's not appropriate under AseraCare. The appropriate thing to do is what the QIC folks have done in these telephone demonstrations and that is, find the information that supports the decision and if it's enough information, then that claim ought to be approved. So I have been very pleased with that whole process. I would recommend anybody who gets invited to participate in it, take them up on the offer, even if they at first say you're going to be on the phone all day or for two days or three days. That's not been my experience. It's very worthwhile and, as opposed to going through the uncertainty of just leaving it to the QIC to figure out in writing what the appeal is, I think it's a great way to focus the appeal going forward and get some good decisions out of it. So I'm glad to see us doing it. I hope this demonstration gets expanded. It was just expanded to hospices last year, so I hope it just continues to live and gets over to Maximus as well.
Meg Pekarske	You keep using this word "invited." So you can't – I mean, listening to you, I'd want to run out and request and please choose me, choose me. It sounds like you can't necessarily say I want this.
Bryan Nowicki	No. The way it's come to us is we are alerted that the QIC has identified certain patients and claims as eligible for the program. Now there's nothing that would prohibit you from reaching out to them and saying, hey, can you put me in line? I'm not sure what their reaction would be, but I would – the way we've come to it is the QIC has given us, our clients, notice that these claims are eligible. If you're interested, fill out this form and return it in seven days or something, and then you're off.
Meg Pekarske	And I think keeping this kind of glimmer of hope is – I think likewise at ALJ, despite the long backlog, I think ALJs are also more reasonable in how they're looking at some technical issues as well. And so I think that is a good thing and where we started this section was the ALJ backlog and is the appeal process working and are things that should be getting paid getting paid because, essentially, there's a backlog because too much stuff is getting there that then maybe is getting overturned by the ALJ. Not that the ALJ isn't going to overturn, but shouldn't some of this get sorted out through the multi levels of appeal so yes, I think that's really hopeful. And I think while we've seen a diversity of clients get this ask in terms of how many claims are at issue, I mean, some of these, it came from a SMRC appeal so there were lots of claims involved so the

Speaker	Statement
	dollar numbers are pretty huge. I mean, others it's been single claims, but this could have a real positive financial impact for the client so worth their energy and time in both preparing and then, obviously, preparing us, or paying us, to help in terms of facilitating this process.
Bryan Nowicki	Yeah, with a patient – I think there were about 30 claims at issue, so you can do the math on how much that's worth. I mean, that's a lot of denied funds out there and in the space of a two-hour call with the QIC that was scheduled originally to last for three days, we wrapped it up in two hours. I think we resolved all of those claims favorably, so well worth the investment. And I have found the people at C2C who are involved in these calls, they're very well prepared. They know the record in and out because they're combing through it to find the information that supports it. And so, yeah, you don't need to invest a lot of time and the potential positive is very, very good.
Meg Pekarske	I appreciate you sharing that and that's enthusiasm if I was ever going to hear it out of your voice, Bryan. It's like Yoo-Rah-Rah!
Bryan Nowicki	It's so nice to have a conversation. I mean, for years that's – and I've told them this – I think this is great. This should happen at every stage of the appeal, because look how much we're accomplishing just by being able to talk and for not a long amount of time, but just being able to talk about these things. I'm hopeful this will be expanded because I think it's a very helpful process.
Meg Pekarske	Yeah, absolutely. As we always go into these, like, oh, we don't have that much to say and then nearly an hour later, our podcast is wrapping up here. So I think this is a really interesting conversation. We hit on a number of very important topics, obviously not all COVID-related because things are marching on despite the public health emergency. But I think that both some insights into what we're seeing on the front lines, some strategies, and then – because we always want to end with hope, so Bryan, you're bringing the cause for hope to finish up here. But anyway, thank you very much for sharing your expertise and time. I think it was a good conversation and hopefully our listeners will have found it valuable too. So thank you very much.
Bryan Nowicki	Great. Thanks Erin, thank you Meg. Nice talking with you.
Meg Pekarske	Well that is it for today's episode, "Hospice Insights: The Law and Beyond." Thank you for joining the conversation. To subscribe to our podcast, visit our website at huschblackwell.com, or sign up wherever you get your podcasts. Until next time, may the wind be at your back.