Predictive Modeling Provider Tip

Policy: Medicaid Provider Manual;

Chapter: General Information for Providers, **Section**: 15 Record Keeping; **Subsection**: 15.7 Clinical Records
Chapter: Billing & Reimbursement for Institutional Providers, **Section**: 1.2 Predictive Modeling
Chapter: Billing & Reimbursement for Professionals, **Section**: 1.2 Predictive Modeling
Chapter: Billing & Reimbursement for Dental Providers, **Section**: 1.2 Predictive Modeling

1.2 PREDICTIVE MODELING

Predictive modeling, a pre-payment claims process in CHAMPS, uses advanced screening technology to identify Medicaid claims with billing irregularities. Claims flagged by the predictive modeling process will undergo a detailed analysis to determine the next step(s) to be taken. This may include a review of medical records and/or past claims. Providers must submit the requested records within 45 days of the date on the request for documents letter to avoid denials for lack of documentation. Records should not be submitted prior to receiving a request for documentation letter.

Requested records must be submitted through the Document Management Portal available in CHAMPS.

Refer to:

- The MDHHS website for information and tutorials on the Document Management Portal.
- The Directory Appendix for Document Management Portal website information.

Effective 2/2/2013, Predictive Modeling (PM) was implemented to identify billing irregularities prior to payment of a claim. In general, CHAMPS suspends any claim with a billing irregularity, whether it be due to all other claims incurred by the beneficiary, an overutilization of services by the beneficiary, or if the provider has billed the same account several times with denials and continues to make changes to the claim that passes prior editing. Several billing scenarios prompt PM to flag hospital claims. It is important for providers to ensure that when an account sets for PM and the medical records request letter is issued, that the proper documentation be supplied within the appropriate timeframe.

Additional resources: The Medicaid Provider website – www.michigan.gov/medicaidproviders > CHAMPS > CHAMPS Functions > External Links:
Document Management Portal (DMP) > DMP Tutorial – PDF
Predictive Modeling > Predictive Modeling FAQ's and Medical Request Letter (Sample)

The Predictive Modeling Process

1. Once a claim has passed all CHAMPS editing, including beneficiary/provider eligibility, third-party liability (TPL), diagnosis and procedure code validity, etc., the claim runs through the Predictive Modeling software.
    a. Any claim that has been flagged for review will suspend with the following Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC).
        i. CARC 272: Coverage/program guidelines were not met.
        ii. RARC N10: Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
    b. Once the claim suspends for Predictive Modeling, the following CARC/RARC is appended to the claim for the initial documentation request
        i. CARC 252: An attachment/other documentation is required to adjudicate this claim/service.
        ii. RARC N706: Missing documentation.
2. The claim is suspended in CHAMPS for Predictive Modeling. CHAMPS generates a Predictive Modeling medical request letter that is sent to the provider.
    a. The initial PM letter is sent to the correspondence address listed in CHAMPS. The letter is also uploaded to CHAMPS under My Inbox > Archived Documents > MP Predictive Modeling.
    b. The PM claim can suspend up to 120 days, sometimes longer depending the scenario.

3. When the PM letter is issued, the provider has **45 calendar** days to upload the necessary medical records/documentation through the Document Management Portal (DMP) to the TCN that is being audited.
    a. For additional resources for uploading to the DMP, please reference the Tutorial – PDF
4. The PM documentation is reviewed. If determined documentation is missing and/or additional information is needed, another edit is appended to the claim. A message is sent through the DMP to advise additional information is needed. The provider has **10 business** days from the additional information request to respond.
    a. The DMP message is sent to the person that uploaded the medical documentation.
5. The system maintains tracking of time frames for Predictive Modeling claims requiring documentation.
    - If PM documentation is not received within 45 calendar days from the initial PM request letter, the claim will be denied.
    - If PM documentation is not received within 10 business days from the additional PM documentation request, the claim will be denied.
6. If the documentation submitted does not support the claim as billed and/or the documentation is not provided within the proper timeframe the claim will be denied. Several CARC/RARC's will append to the denied claim. Providers can reference the Washington Publishing Company website – http://www.wpc-edi.com for explanation of the CARC/RARC's.
7. When the appropriate documentation has been received, reviewed and approved, the claim will pass the Predictive Modeling audit. The claim is then back through the CHAMPS processing edits including verification if other claims were submitted and paid while the claim was suspended, PACER requirements, beneficiary/provider eligibility, third-party liability (TPL), diagnosis and procedure code validity, etc.
8. Once claim passes the Predictive Modeling audit and does not flag for any other edits, the claim should no longer show suspended, as the Predictive Modeling and claim review process is complete.

Uploading PM documentation

- All documentation submitted should be organized and clearly identified with the patients' name and/or account number. Examples of medical documentation is provided below – see page 3
- It is extremely important that the PM documentation is uploaded correctly to the DMP.
    - The documents must be uploaded to the suspended claim with the "Document Type" = ***Claim*** and "Document Title" = ***Predictive Modeling***. *If uploaded incorrectly, the information will not be reviewed.
    - For additional resources for uploading to the DMP, please reference the Tutorial – PDF
- **Documentation must be uploaded after the initial PM medical request letter is issued.** Due to audit constraints, MDHHS **does not** review PM records/documentation submitted prior to the initial PM medical letter request.
- **DMP messaging:** While the medical documentation is being reviewed, the processor may request additional medical documentation by sending a message via the DMP.
    - If you believe a requested document was already included/previously uploaded, reply to the DMP message with the document # and the page # where the document can be found. The message must be specific.
    - If a message sent to the provider is not understood, please contact Provider Support at 1-800-292-2550 or email ProviderSupport@Michigan.gov for assistance.
    - When emailing Provider Support, review the link Contact Provider Support and provide the appropriate completed template.

Questions regarding the PM determination

- If a Predictive Modeling claim denies, make sure to review the RARC's associated to the denied claim. Providers can reference the Washington Publishing Company website – http://www.wpc-edi.com for explanation of the CARC/RARC's.
    - If you disagree with the determination after reviewing the RARC's, email ProviderSupport@Michigan.gov and request a **second** review.

  - When emailing Provider Support, review the link Contact Provider Support and provide the appropriate completed template.
- If after the **second** review, you still disagree with the decision, the provider has the right to file an appeal.
  - Prior to filing a formal appeal, please work with Provider Support to ensure the claim was processed appropriately.
  - For information regarding filing a formal appeal, click on the following link Michigan Office of Administrative Hearings and Rules for Michigan Department of Health and Human Services
- **Organization/Timely Filing:** Providers should be familiar with Michigan Medicaid's Timely Filing Policy. For resources available, reference MSA Policy 16-37 and/or the Medicaid Provider Manual, **Chapter:** General Information for Providers, **Section:** 12.3 Timely Filing Billing Limitation.

  Effective January 1, 2017, claims must be filed no later than one calendar year from the date of service (DOS). For Institutional invoices, this will be calculated using the Claim Header "To/Through" date of service reported; for Professional and Dental invoices, this will be calculated using the Claim Line "From" date of service. All claims must be resolved within one year from the date of service unless an appropriate exception exists. Review the policy and Medicaid Provider Manual for the allowable exceptions.

Examples of Requested Medical Documentation

For an Inpatient Hospital Claim:

1. Admission to Inpatient Summary.
2. History and Physical.
3. Order to admit to inpatient status and the status must be clear. This record must be dated, time stamped, signed by the attending practitioner and match the account as billed.
4. If any MRI or CAT scans are performed, there must be proper supporting documentation of the order/results.
5. If the patient was admitted through the emergency department, the emergency report is required.
6. For any surgical procedures, the documentation should include a copy of the operative report and any anesthesia records.
7. Consultation reports.
8. All practitioners' orders, nursing notes, reports of treatment, medication administration records, radiology and laboratory reports, vital signs and any other information necessary to monitor the patient's condition.
9. Physical, Occupational and/or Speech therapy orders and reports including any evaluation records.
10. Discharge Summary which includes a complete description of the course of treatment for this stay, patient care, reactions/outcome dispositions of the case, the medical decision making during the admission and provisions for follow-up care.
    a) Reason for hospitalization
    b) Significant findings.
    c) Procedures and treatment provided.
    d) Patient's discharge condition.
    e) Patient and family instructions (as appropriate).
    f) Attending physician's signature.
    g) The patient's discharge instructions.

For an Outpatient Hospital / Professional Claim:

1. If a test is rendered, submit the order and the results. Results must be specific not just an indication of “normal” or “abnormal”.
2. Operative report.
3. Recovery room records.
4. Labor and delivery records.
5. Observation admission records that include date/time of admission through discharge.
6. Orders to admit to observation status and the status must be clear, time stamped, dated and signed by the ordering practitioner.
7. Anesthesia record.
8. History and physical.
9. Medication orders plus the medication administration record (MAR).
10. Chemotherapy/Radiation Therapy must properly document orders, plan of care, and administration of such services as well as any significant patient outcomes.
11. Clinic notes.
12. Office visit notes.
13. Procedure room notes.
14. IV orders and flow charts.
15. Emergency room notes/report.
16. Infusion flow sheets.
17. Consultation reports.
18. Therapy orders and reports of treatment rendered/results.
19. Cast room notes.
20. Dialysis orders and reports that document plan of care and administration of dialysis treatment rendered/results.
21. Education, training, order and report of treatment rendered and results and/or notes.
22. Rehab orders and reports of treatment rendered and results and/or notes.