Billing Tips –Hospital
Predictive Modeling/Document Management Portal (DMP)

How to reduce administrative burden and stream line your processes. All hospital claims go through the Predictive Modeling (PM) software including claim adjustments. 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 as there is an associated administrative cost and burden to both the provider and to the State of Michigan (SOM).

Policy: Medicaid Provider Manual (MPM) Chapter "General Information for Providers" Section 15-Record Keeping and Chapter "Billing & Reimbursement for Institutional Providers" Section 1.2 Predictive Modeling.

The goal of PM implementation: Effective 02/02/2013, PM was implemented to identify billing irregularities prior to payment of a claim. In general, the system suspends any claim with a billing irregularity whether it be due to all other claims incurred by the beneficiary, if there is 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.

Example scenario of when the PM edit set: PM compares a suspending claim to all of the beneficiary's history of paid/denied claims and finds that multiple providers have billed claims for the same services in five different counties in the SOM for the same date of service and same procedure code. The procedure is a specific lab code. In this example, the fifth claim is flagged with the PM edit, the claim is suspended and an analysis occurs to determine if it is appropriate or possible for this patient to be in five different counties on the same date of service. The beneficiary's claims history is reviewed and it is determined that it would be unusual for the same test to be done five times on the same date of service and a PM medical request letter is issued.

The process: Once a claim has passed all of the CHAMPS editing including beneficiary/provider eligibility, third party liability, prior authorization, diagnosis validity, procedure code validity etc., the claim is directed through the PM software. Any PM hospital claim that is suspended will be subject to a set of edits that are internally manually amended to the claim in a logical sequence.

- **First,** an internal edit is amended to the claim that makes the system release a PM medical request letter to the provider. Capability to manually edit each letter is now in place versus prior practice of utilizing the same form letter for each and every claim.
- **Second**, once the provider responds by uploading their medical records through the Document Management Portal (DMP) to the Transaction Control Number (TCN) that is being audited, the SOM staff manually amend another edit to the claim. The claim is directed to the work queue where claims with documentation are analyzed.
- **Third,** if the PM worker reviews the documentation and something is missing, a message is sent through DMP to the documentation submitter asking for additional specific documentation that is missing. The provider has 10 business days to respond. Another internal edit is amended to the claim. The claim is then moved to another queue.

- **Fourth,** the system maintain tracking of time frames. The system counts 45 days from the initial PM request letter. If documentation submitted from the initial request is inadequate and a message was sent through the DMP, the system counts 10 additional business days from the original request for documentation.

- **Fifth,** if the documentation submitted does not support the claim as billed, several internal edits may be amended to the claim to detail the denial reasons. These internal edits crosswalk to edits found on the Washington Publishing Company reason and remarks codes (see below grid).

- **Sixth,** if the provider does not upload documentation in a timely fashion, a weekly automated system action will deny all claims suspending with no or inadequate documentation.

Timing is crucial: MDHHS does **NOT** review PM records submitted prior to the issuance of the PM medical request letter due to audit constraints. If the provider does not upload requested medical records in the proper sequence or if the provider uploads medical records to the suspending TCN prior to the issuance of the PM medical request letter, it will not be in the correct SOM work queue and will be denied by the automated process.

Other actions may delay completion of suspended claim: Once the PM audit is passed, and the claim is approved, the claim again goes back through the CHAMPS front end and is re-edited. If other claims came in and were paid while this TCN was suspending, it may set needed PACER edits. If the Third Party Liability (TPL) information has changed on the members tab in CHAMPS, a TPL edit could set.

Organization/Timely Filing: Provider Relations Section (PRS) staff have been notified by several hospitals that PM is handled by their Recovery Audit Contractor (RAC) audit section as they are best equipped to review and understand medical records in comparison to diagnosis coding and other coding issues on their claims. It is important for providers to ensure when an account sets for PM, and the medical records request letter is issued, the proper documentation be supplied the first time the claim is filed as there is an associated administrative cost and burden to both the provider and to the SOM to repeatedly file and review the same account.

In 2017, the timely filing policy has changed per MSA 16-37. The intent of this policy change is to eliminate the ongoing continuous activity portion of the timely filing policy. Any claim not received within one year would only be considered for payment if an exception was requested (exceptions are outlined in the online MPM), properly documented, and approved by MSA claims processing staff. Any claim for services issued prior to 01/01/2017 MUST be submitted no later than 12/31/2017. The intent of this policy change is to eliminate the ongoing continuous activity portion of the timely filing policy for all claims incurred prior to 01/01/2017.

DMP tips: Providers need to ensure that their staff is using the correct selections to route their documentation to the PM suspending claim. Based on what is selected within the DMP Document Upload options, it labels/tags the documents so that PM reviewers know what was intended to be used during the PM audit. Always select "Document Type"=***Claim*** and "Document Title"=***Predictive Modeling***.

If a message sent to the provider is not understood, please call the Provider Support phone 800 292 2550 for assistance. If a requested document that you believe is already included in the previously uploaded documentation, send a DMP message back with the DMP document# and the page# where the documents may be found. The information must be specific.

Documentation Issues: A logical list of what is required may be created but please note that one facility may include on a document they have titled "Discharge Summary" certain information whereas at another facility, that document with that same title does not include all of the criteria needed to make the PM audit decision. Per current policy, providers are advised to appropriately bill services with the diagnosis coding to the highest level of specificity. Any diagnosis indicated on the claim and all services rendered must be documented properly within the patient's medical record. If services cannot be properly documented, they may not be billed to MDHHS or to the beneficiary.

The PM medical records request letter is usually a form letter and is very generic. Provider Relations receive a lot of questions as to what is "really" needed.

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, and 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. If the patient has 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 condition.
9. Physical, occupation 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.
11. The patient's discharge instructions.

* The Joint Commission on Accreditation of Healthcare Organizations mandates that six components be present in all U.S. hospital discharge summaries. Hospital discharge summaries serve as the primary document communicating a patient's care plan to the post-hospital care team. Often, the discharge summary is the only form of communication that accompanies the patient to the next setting of care. High-quality discharge summaries are generally thought to be essential for promoting patient safety during transitions between care settings, particularly during the initial post-hospital period. The six components required in the discharge summary are:

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.

For an Outpatient Hospital 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.

Follow up: The more organized the documentation, the faster SOM staff will be able to review and approve your claims. All documentation should be clearly identified with the patient name and or account number. In a well-documented medical record, there may be several types and sources of documentation supporting the necessity of the services provided. The primary objective in preparing clinical documentation should be to assure that a qualified reviewer can easily determine what was done for the patient and the clinical rationale for the services provided. CMS recognizes that records in some cases may be amended. To be included in the medical review, all late amended entries must be clearly identified and the original content must not be deleted. Any amendment should be time and date stamped together with the identification of the author. Orders may not be back dated.

It may not always be clear as to why PM has denied your claim. Review all of the Remittance Advice Reason Codes (RARC) associated to the denied TCN. Review the claim using the CHAMPS claims inquiry functions and review documents attached to the TCN. Only the documents attached to the TCN were used in the audit. Review the documents to ensure that all services were properly documented. If there are any charges on a hospital's claim that cannot be supported, these charges must be removed as it is not possible for SOM to deny parts or portions of claims at the service line level. Services not properly documented may not be billed to Medicaid or to the beneficiary.

If the provider cannot determine the specifics of the PM denial, contact the SOM to inquire what was lacking or deficient. If the provider finds the documentation within the materials attached to the TCN in CHAMPS, the provider needs to specifically define where the document(s) are by identifying the DMP document number and page number and communicate this to PRS and ask for a second review. MDHHS prefers to receive these inquires at ProviderSupport@Michigan.Gov . Your TCN will be forwarded to the PM staff for a second review. It normally takes approximately 20 days for a second review and response. If the provider still disagrees with the second review decision, the provider may use a copy of the email response as part of their position paper in the MDHHS appeal process.

Appeals: The provider has the right to appeal any adverse action. A claim rejection is an adverse action. We strongly advise providers to first work with PRS staff to receive a review of any claim denial

for policy, billing and reimbursement advice. If provider wishes to move forward with an appeal, they should work directly with MDHHS Appeals Section staff. For information regarding the appeal process please see their website for details: http://www.michigan.gov/mdhhs/0,5885,7-339-73970_5093-16825--,00.html

The SOM appeals contact information (phone numbers/fax numbers) may be found in the MDHHS online Medicaid provider policy manual in the directory appendix. www.Michigan.Gov/MedicaidProviders >>Policy and Forms.

All requests for a hearing/appeal must be in writing. The hearing request should provide the name, address and telephone number of the person from whom the hearing is being requested. The materials submitted shall include any claim denial information and should be clearly identified with the NPI, beneficiary ID, date of service and any TCN(s). The request should identify the specific adverse action with which you disagree, explain the reasons for your disagreement and the dollar amounts involved, if any. Please include any substantive documentary evidence to support your position. In addition, you should specifically identify whether you are seeking a preliminary conference, a bureau conference or administrative hearing. If you received any written review of your claim denial from the MDHHS PRS staff, this document(s) may be included with your evidence.

Crosswalk from internally amended codes to the WPC:

Internal Error Code	Short Description	Adjustment Reason Code
08946	Admit notes missing	252 - An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).
08901	Admit orders Missing	250 - The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).
08902	Beneficiary data missing from documents	251 - The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).
08903	CMN - Certificate of Necessity missing	252
08936	CMN - Certificate of Necessity not completed	251

08202	Confirmed not to be a resubmission	216 - Based on the findings of a review organization
08929	Conflict inpatient/Outpatient	60 - Charges for outpatient services are not covered when performed within a period of time prior to or after inpatient services
08904	Consultation notes missing	252
08937	Consultation notes not legible	251
08905	Dates of Service Don't Match Documents	250
08906	Dates on form are missing	251
08938	Dates on form are not legible	251
08939	Dates on form are not valid	251
09009	Deny claim after document required date has passed	272
08930	Diagnosis Code missing on Lab Order	16 - Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
08932	Discharge summary does not support Inpatient stay	251
08940	Discharge summary is not legible	251
08907	Discharge summary missing	252
09007	DMP documentation received after message sent	96 - Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note:

		Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
09006	**DMP message received**	**131- The disposition of this service line is pending further review.**
09005	**DMP message sent from SOM to the provider**	**252**
08933	**Documentation does not support the Diagnosis Code billed**	**251**
08908	**Documents not Legible**	**251**
08909	**Duplicate of a Paid or Suspending Claim**	**18 - Exact duplicate claim/service (Use only with Group Code OA except where state workers'' compensation regulations requires CO)**
08941	**Emergency Room notes are not legible**	**251**
08910	**Emergency Room Notes missing**	**252**
08911	**History and Physical Missing**	**252**
08912	**Infusion chart Missing**	**252**
08913	**Lab Orders Missing**	**252**
08914	**Lab results Missing**	**252**
08915	**Labs ordered not supported by diagnosis (Phys Claim)**	**96**
08916	**Labs Unbundled**	**16**
08917	**Level of service billed not supported by documentation**	**150 - Payer deems the information submitted does not support this level of service.**
08942	**Medication Record incomplete**	**251**

08918	Medication Record Missing	250
08919	Mileage on claim not supported by trip sheet	16
08999	Multiple documents missing	252
08920	Observation Orders Missing	252
08921	OP Report Missing	252
08934	Orders missing for Procedures billed	252
08943	Physician Certification Statement (PCS) incomplete	251
08922	Physician Certification Statement (PCS) missing	252
09001	Predictive Modeling (CS) Additional Documentation Requested	252
09002	Predictive Modeling (CS) Documentation Received	96
08002	Predictive Modeling (CS) Forced Determined	101 - Predetermination: anticipated payment upon completion of services or claim adjudication.
08003	Predictive Modeling (CS) Forced Improper Billing	96
08001	Predictive Modeling (CS) Forced Undetermined	223 - Adjustment code for mandated federal, state or local law/regulation that is not already covered by another code and is mandated before a new code can be created.
08004	Predictive Modeling (CS) No Medical Records Received	252
09000	Predictive Modeling Flagged For Improper Billing	272 - Coverage/program guidelines were not met.
08923	Procedure Service not documented in submitted records	B12 - Services not documented in patients" medical records.

08944	Provider Signature Altered	251
08924	Provider Signature Missing	251
08945	Provider Signature not legible	251
08925	Radiology Report Missing	252
08926	Refill Verification Missing for DME	252
08935	Rendering Provider billed does not match documentation.	16
08201	Resubmission of a Denied or Suspending Predictive Modeling Claim	97 - The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
08927	Services billed not supported by diagnosis	11 - The diagnosis is inconsistent with the procedure. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
01705	Submitted documentation not adequate	251
08928	Therapy Notes Missing	252