HMS Clinical Retrospective

DRG Clinical Audit and Review Process

Purpose

1

Understanding the Review Solution

Provide an overview of the DRG Validation Review Solution.

2

Understanding the Review Process

Provide an overview of our medical record request and review process.

3

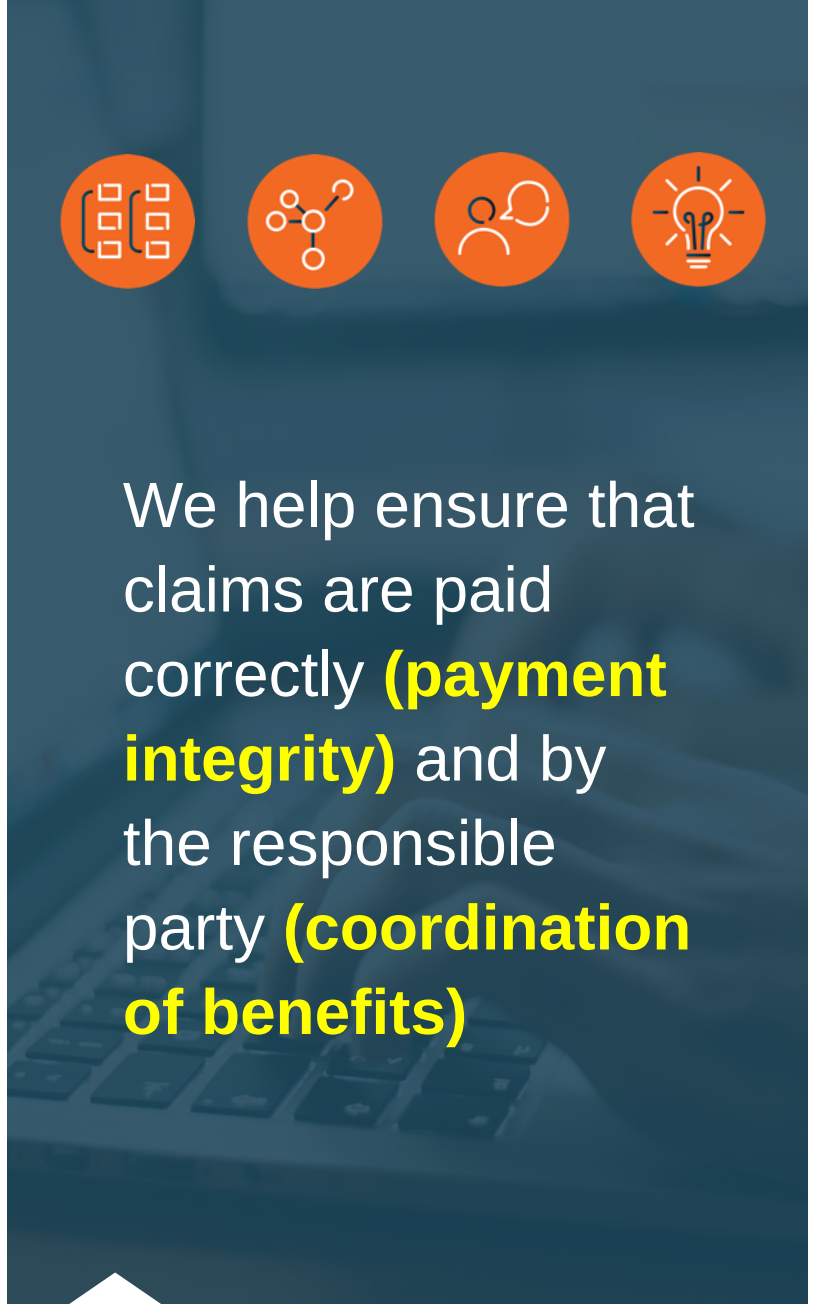
Collaboration and Communication

Ensure questions and concerns are addressed and providers know how to contact HMS for questions and support.

HMS Overview

Leading the healthcare industry in cost containment

- Founded in **1974**
- National presence
  - **350+** health plan clients
  - **50+** US federal and state government agencies
  - **160+** employer clients
- More than **100 million** Americans under contract
- **3,100+** employees
- We help ensure that claims are paid correctly **(payment integrity)** and by the responsible party **(coordination of benefits)**



Review Process

Overview of Audit Process

Analytics and Data Mining

- Client health plan policy and contract analysis
- State and federal regulatory review
- Scenario design or audit concept development
- Data analytics and claims identification based on policy guidelines

Record Request

- Claim or set of claims selected for review
- Medical record request
- Medical record receipt

Review and Audits

- RN, coder, pharmacist and behavioral health professionals
- Physician referral and review
- Quality assurance

Notification and Recovery

- Determination notification letter
- Reconsideration and appeals

Education

- Provider relations and education
- Program and quality recommendations
- Info sheets and website

Analytics and Data Mining

- HMS works in partnership with our health plan clients to determine the appropriate audit concept and identify claims for review based on criteria set forth by the health plan
  - Client policy and contract analysis
  - Industry standard, state and federal regulatory review
- HMS uses innovative algorithms, driven by large data sets and machine learning technologies, to identify claims for review
- By applying advanced analytics to the paid claims, those with a high likelihood of error are accurately identified
- Medical records will only be requested for the claim or set of claims selected for review

Medical Record Requests

Medical Record Requests

You will receive a notification letter.

- If your facility is chosen for an review, a letter will be mailed to the medical records department informing them of the upcoming review.

Instructions are included.

- The letter will include instructions for submitting the medical records, the list of claims to be reviewed, and the number of days you have to submit information.

Sending medical records electronically is preferred.

- The preferred method of sending medical record files is electronically, though HMS can accept them in other formats.

HMS protects your data including PHI.

- HMS protects data provided by providers and health plans using the highest security standards in the industry.

For questions about how to submit records electronically, please contact **GoGreen@hms.com**

- If the medical record is not received in the requested time, HMS will make courtesy calls and mail follow-up letters.
- Reimbursement for medical records is determined by the health plan client and based on the language in your payer contract.
- A dedicated line may be created for client specific inquiries, if a dedicated line is used, you will receive this toll free number view our medical record request letter.

Submitting Medical Records

Electronic Method

Sending files electronically is the fastest, most convenient and preferred method

- Data is sent via secure file transfer protocol (SFTP) or through the HMS Provider Portal if your health plan has chosen this option -- both methods are secure
- To set up an SFTP connection, emails us at GoGreen@hms.com.
- Self Register for a Provider Portal account at: https://ecenter.hmsy.com/external/SelfRegister.jsp or email us at hmsppuserverification@hms.com

To start sending files through your new connection, keep this in mind:

- Ensure your documentation is legible with good quality image scans.
- Records should support the level of care provided for the dates of service requested, including inpatient admission orders, physician documentation and notes, and physician orders.

Important check point:

- If your medical records systems use a PowerPlan®-type digital signature documentation, ensure the authentication or validation is included with your medical record submission.

Submitting Medical Records

Alternate Process

Additional options for submitting documentation include U.S. Mail

If you choose this alternate methods, keep in mind:

- Ensure your documentation is legible with good quality image scans.
- Records should support the level of care provided for the dates of service requested, including inpatient admission orders, physician documentation and notes, and physician orders

Important check point:

- If your medical records systems use a power-plan type digital signature documentation, ensure the authentication or validation is included with your medical record submission.

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DRG Validation Review

DRG Clinical and Coding Validation

HMS Reviews Targeted DRG Claims

HMS verifies that all diagnoses and procedure codes were billed appropriately in accordance with official coding guidelines and were consistent with the documentation in the medical record, resulting in accurate DRG assignment and reimbursement.

DRG Coding Validation

Coding validation is the process of verifying that codes were billed and sequenced in accordance with coding guidelines.

DRG Clinical Validation

Verifies diagnoses coded were actually present based on the clinical documentation in the medical record, and the results of related diagnostic testing were consistent with the diagnoses

Purpose of the DRG Validation Review

Validate the principal and secondary diagnoses to ensure all diagnoses were billed appropriately, supported in the medical record and billed according to official coding guidelines.

Validate that clinical documentation and results of diagnostic testing support the billed diagnosis.

Validate all procedure codes to ensure they were coded accurately according to official coding guidelines, and are supported by the documentation in the medical record.

Verify the discharge status code and all other data elements affecting the DRG assignment.

Verify diagnoses identified as Hospital-Acquired Conditions were coded with the correct Present On Admission indicator.

Guidelines and Criteria

HMS uses nationally recognized criteria and industry standard guidelines for establishing diagnoses.

- National coding guidelines
- Industry standard criteria and definitions to substantiate the billed diagnoses codes affecting DRG assignment.
- Criteria that are generally accepted by the medical community from professional guidelines and other evidence-based sources.

DRG Clinical Validation – Sepsis Criteria

HMS uses the Third International Consensus Definition (better known as Sepsis-3) as the evaluation criteria for payment purposes for Sepsis.

This is the standard currently being used in the medical community.

Sepsis is defined as a life-threatening organ dysfunction caused by a dysregulated host response to infection. For clinical operationalization, organ dysfunction is represented by an increase in the Sequential [Sepsis-related] Organ Failure Assessment (SOFA) score of 2 points or more, which is associated with an in-hospital mortality greater than 10%.

Substantiation of this criteria in the medical record would be necessary to clinically validate the diagnosis of sepsis.

Review Process

Review Process

After we receive the requested medical records, one of our experienced clinical reviewers will perform an in-depth review of the submitted documentation.

HMS reviews the claim and submitted documentation to validate that the setting, services, and billing are consistent with the documentation.

Reviews are conducted by nurse reviewer, certified coders and clinical auditors under the direction of HMS medical directors.

The DRG Validation review ensures the billed DRG and coding are consistent with the documentation.

The turn around time is dependent on our contract agreement with our health plan client.

The findings from this analysis are reported to the client, along with recommendations regarding proper payment of the claim.

Reconsiderations and Appeals

Determination Notification

Based on our findings, a determination is made and a notice is mailed to the provider informing them of the results.

If the notice is for a finding of inaccurate billing, we'll provide the claim information and a detailed rationale for the determination.

It's possible a provider may disagree with the audit findings and rationale. We include detailed instructions for disputing the determination in the notice.

Demand and Determination Letters

Finding Notification Letter

- Indicates that a claim review resulted in a finding of an overpayment.
- The packet contains two documents:

01	**Cover letter**	Instructions for next steps and requesting an dispute.
02	**Audit Detail**	A listing of all claims reviewed and indication of whether each claim was approved or identified as an overpayment. A letter for each denied claim will provide specific information to explain why it was denied.

Reconsideration and Appeal Process

The health plan's current appeal process will be utilized

A concentrated effort is made to assure that finding demand letters are detailed and specific, helping reduce the burden of disputes on all parties

Providers are encouraged to call HMS Provider Relations to discuss and resolve issues

Reconsideration and Appeal Letters

Reconsideration Exhaust Letter

- Notification of late reconsideration request submission

Reconsideration Overturn Letter

- Review of additional documentation identifies no findings of improper billing
- No further action needed

Reconsideration Uphold Letter

- Review of additional documentation concludes that initial determination was accurate

Provider Relations

Open Communication

HMS encourages providers to contact us with their concerns and questions

We view our one-to-one discussions as ideal opportunities to provide education, answer any questions and alleviate concerns

Our Provider Relations team stands ready to guide you throughout the entire process

Provider Support

- HMS Provider Relations Line
- (866) 376-2319 dedicated SC RAC specific line
- Provider Education Website www.hms.com/cai

Letter inquiries

Process questions

Claim status verification

Monday through Friday
9 a.m. to 8:00 p.m. EST

Educational Opportunities

Education and Outreach

Format	Purpose	Method	Contact Initiator	Recipient
Introductory Letter or Flier	Provide advanced notice of an upcoming audit and medical record requests	Email or Mail	State	Provider
Info Sheet	Provide a general overview of the audit concept and what to expect during the review	Email or Mail	State	Provider
Provider Website	Provide an overview of the audit concept and review process	Web-based, self-paced videos	HMS	Provider
Provider Deck	Provide an overview of the audit and review process, answer questions and provide solutions	Web-based	HMS	Provider

Moving healthcare forward.

Thank you for attending and we look forward to working together.

For additional information regarding our Clinical Claims Review process, please visit hms.com/cai

hms.com