# MDwise Provider Outreach and Education

Clinical Claim Review
Payment Analytics

gainwell®

# Agenda

1. Introductions
2. MDwise Audit Overview
3. Clinical Claim Review and Payment Analytics
4. Improper Payment Notifications and Disputes
5. Provider Resources

# Introduction

- Chasity Howell, Vice President Provider Services

- Sche Williams, Account Director II
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- Dr. David Johnson, Sr. Medical Director
- Trina McNamara, Solution Architect

# MDwise Audit Overview

# Goals and Objectives

## What is the purpose of the Review?

The purpose of the review is to reduce improper payments through the efficient detection and collection of improper payments and the implementation of actions that will prevent future improper payments.

## What is the goal of the Review?

The goal of the review is to reduce improper payments while also presenting billing education opportunities to providers to improve the accuracy of claims submitted to MDwise for reimbursement.

## Collaboration and Communication

It is necessary to ensure providers understand their role in the program and know how to contact MDwise and HMS for questions and support.

# HMS Summary

# About HMS

**HMS, a Gainwell Technologies Company,** has partnered with MDwise to reduce improper payment while also presenting billing opportunities to providers to improve the accuracy of claims submitted for reimbursement.

## Summary

- Provider of **technology-enabled, mission-critical,** IP-based software and services solutions designed to efficiently support State and Local Medicaid programs and other initiatives
- Medicaid **industry leader** with a strong reputation of service excellence, advanced software development, and **extensive industry/state specific expertise** on strategic implementations and ongoing service

## Key Solution Areas Include

- Analytics
- Medicaid Management
- Cost Containment & Care Quality
- Pharmacy Solutions
- Human Services & Public Health
- Systems Integration and Interoperability

**#1** Provider of Medicaid Services

| | |
|---|---|
| **51** U.S. states and territories are clients | **~25 years** Average relationship length |
| **100%** MMIS customer renewal rate over the last 10+ years | **5-10 years** Typical duration of contracts |
| **~60M** Medicaid beneficiaries supported | **11,500+** Employees |
| **3.7M** Providers served annually | **1B** Claims processed annually |

# Scope and Review Process

# Review Scope

What types of reviews will HMS perform?

## Clinical Claim Review

Identifies improper coding, location/level of service and reimbursement errors by reviewing medical records and other clinical documentation

**Example**

- **DRG Clinical and Coding Validation**

## Payment Analytics

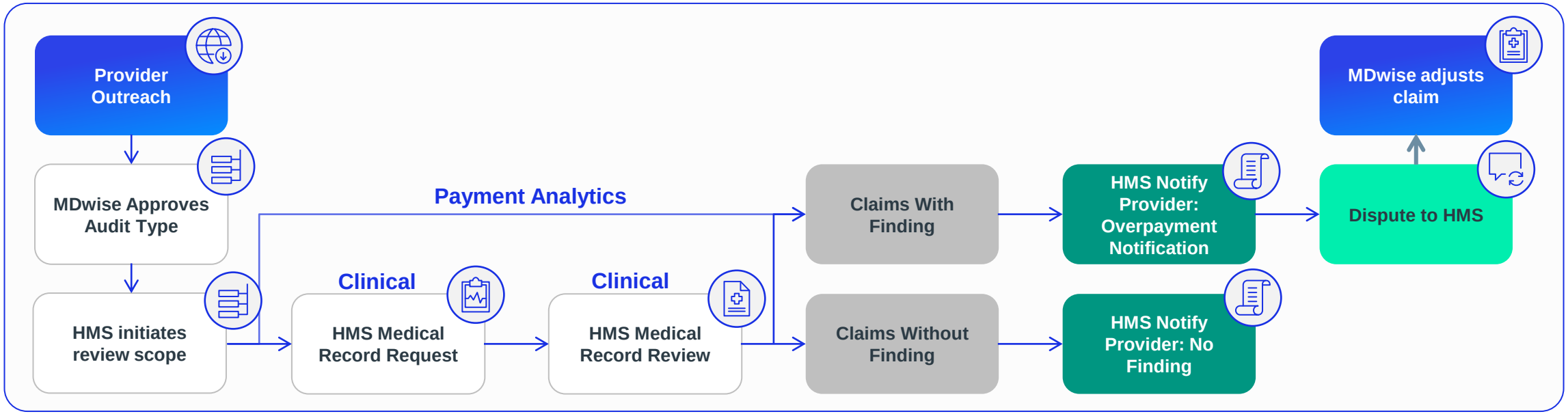
Data-driven reviews identifying improperly billed, coded or paid claims according to regulatory, policy and contractual requirements and industry rules

**Example**

- **Duplicate**

- **Lookback Period:** 24 months from the Discharge Date of Service of the claim
- A lookback period is defined as a threshold applied to the claim data specifying how far back a review will occur.
- **Claim Types:** All claim and provider types are subject to review under the audit program. The scope of the audit is reviewed and approved by MDwise prior to HMS conducting audit.

# Overview of Review Process




## Review Process

- Medical record request serves as notification of review.
- Providers will have 30 days to submit a medical record. Follow-up Medical Record Request letter will be mailed if not received within time frame.
- Medical records are reviewed by HMS.
- Finding Notification will be mailed to provider with Dispute instruction for submission to HMS.
- If the medical record review resulted with no improper payment identified, providers will receive a No Further Action letter.
- Once the Dispute time frame has exhausted, overpayment will be adjusted by MDwise.

# Medical Record Requests

# Medical Record Requests

**You will receive a notification letter**

- If your facility is chosen for a review, a letter will be mailed informing you of the upcoming review. MDwise will determine mailing limitations to all medical record requests.
- Medical Record Request letters will be sent via USPS Mail to the address provided by MDwise.
- Please ensure your address is correct or up to date with MDwise.

**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 in which to submit documentation.

**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@gainwelltechnologies.com**

- If the medical record is not received within the requested time, HMS will mail a Follow Up Medical Record Request Letter.

- A dedicated HMS Provider Services toll-free number is available for any inquiries:

  **855-714-0977**

# Submitting Medical Records

**Electronic Method**

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

- Self register for an HMS Provider Portal account at: https://hmsportal.hms.com
- To set up an SFTP connection, email us at GoGreen@gainwelltechnologies.com
- Data is sent via secure file transfer protocol (SFTP) or through the Provider Portal – both methods are secure

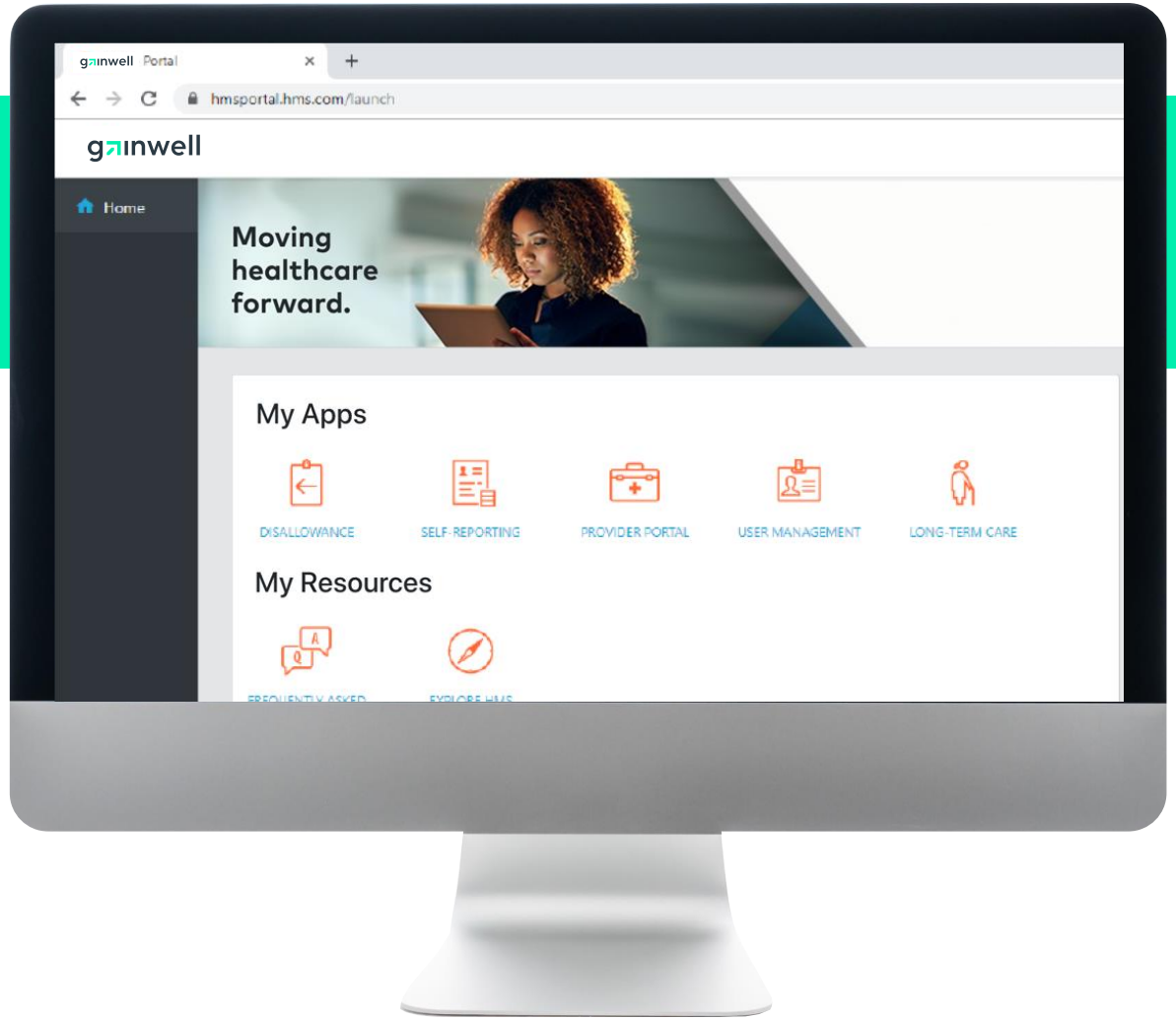
**Medical record documentation should include:**

- Legible documents with good quality images.
- The complete medical record to support the services provided and billed for the dates of service requested.
  - Examples include, but are not limited to: Physician Orders, Physician Progress Notes, Discharge Summary, History and Physical, Operative Reports, Consultations, Diagnostic Results, UB04, etc.
  - Please note: Missing or incomplete medical record submission may result in a technical denial or finding.

# Gainwell Provider Portal

**Cloud-based solution that allows providers to manage activities with HMS**

- Significant improvement in speed
- Increased quality
- Reduction in costs (mailroom, paper)
- Improved provider experience



# Provider Portal Features and Capabilities

## Portal Features

- Near real time (24 hour) claim status updates with HMS PI Platform (medical record receipt, review result, rebuttal status, letters)
- 24/7 access to claim status information
- Dashboard View providing status of all historical and current claims in audit
- HMS Provider Services support for ongoing education, user registration, and inquiry resolution
- HMS HelpDesk support with Portal user access issues (i.e. lockout)
- Detailed User Guide available in Portal (step by step instruction)

## Provider Capabilities

- Locate medical record requests
- Upload of medical records documentation
- Submit a dispute
- View, print, and obtain copies of HMS Letters
- Verify status of claim
- My Workload Queue reflecting all claims outstanding requiring provider action
- Claim Export Status Report

# Place of Service (POS) Review

# Place of Service Review

The POS review verifies that the place of service billed was consistent with the patient's condition and the care and services provided, as documented in the medical record.

We are performing a review of the medical record to validate that the level of care matches the clinical documentation.

This is not a medical necessity determination of services.

The review results ensure payments are consistent with the services provided.

If HMS finds an inpatient stay billed in error, in most cases the provider can rebill the claim for the level of care and services associated with the appropriate setting.

# Guidelines and Criteria

- HMS reviews targeted claims to verify that inpatient level of care was billed appropriately according to MDwise policy and State and Federal regulations.
- The reviewer will use InterQual criteria and clinical review judgement to review the medical record and determine whether the claim has been billed consistent with the care delivered. Specifically, the reviewer will determine whether the patient's conditions and the care provided required an inpatient hospital level of care or if the care could have been safely delivered and is routinely provided in a less intensive level of care or location.
- The HMS physician team provides oversight at all levels of review, assisting reviewers with cases as needed, and directs the quality and dispute activities.

# DRG Clinical and Coding Validation

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## HMS Reviews Targeted DRG Claims

HMS verifies that all diagnoses and procedure codes were billed appropriately in accordance with ICD 10-CM Official Guidelines for Coding and Reporting and are 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

Clinical validation verifies diagnoses coded were present based on the clinical documentation in the medical record, and the results of related diagnostic testing were consistent with the diagnoses.

# DRG Clinical and Coding Validation Elements

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.

ICD 10-CM Official Guidelines for Coding and Reporting

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-3 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.

# Clinical 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.

HMS’s quality program ensures determinations are accurate and consistent with guidelines.

The turnaround time is dependent on our contract agreement with MDwise.

**The medical record review results are reported to MDwise, along with payment decision outcomes.**

# Payment Analytics

# Payment Analytics

Identifies claims improperly billed, coded, or paid according to regulatory, policy and contractual and industry rules

HMS executes proprietary rules engine against paid claim data to identify improper payments.

Medical record is not required to determine an inappropriate payment – identification occurs by comparing rules to claim data elements.

HMS proprietary rules engine is configured with rules customized to MDwise's specific policy and direction.

MDwise approves each improper payment type prior to any audit activity is initiated.

**The findings from this analysis are reported to MDwise.**

# Improper Payment Notifications and Disputes

# Determination Notification

Based on the findings of the review, a determination notice is sent to the provider with the results.

If the notice is for a finding of inaccurate billing, HMS provides a detailed clinical rationale to support the determination.

It’s possible you may disagree with the review findings and rationale. We include detailed instructions for disputing the determination in the notice you receive.

# Finding Notification

## Finding Notification Letter

- Indicates that a claim review resulted in an improper payment and provides dispute instruction to HMS.
- The notification letter is comprised of:

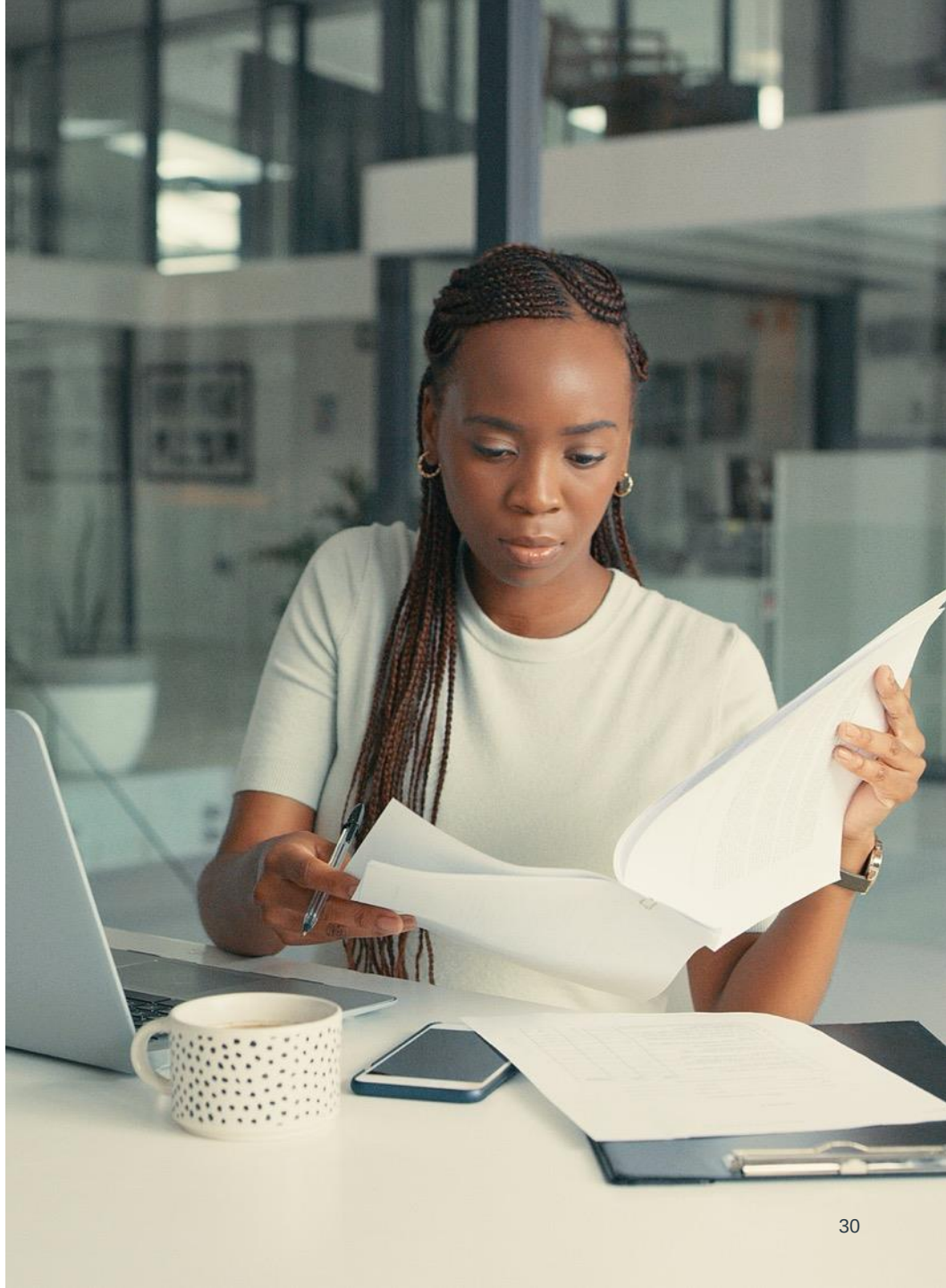
### 01. Cover letter

- Instruction for provider agreement
- Instructions for requesting:
  - Dispute in writing
  - Request must be received within 90 calendar days

### 02. Audit Detail

- A listing of all claims reviewed and determined to have an improper payment.
- For each claim, the audit detail will provide the rationale for the improper payment.

- If a medical record review was performed and resulted in no improper payment determination, the provider will receive a No Further Action Required letter



# First Level Dispute Process

Dispute in writing within 90 days of notification of improper payment to HMS.

A concentrated effort is made to assure that finding 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.

# Dispute Response Letters

**Dispute Exhaust Letter**

- Notification of late dispute request submission

**Dispute Overturn Letter**

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

**Dispute Uphold Letter**

- Review of additional documentation concludes that initial determination was accurate

# Second Level Dispute Process

Second Level Dispute in writing within 60 days of the First Level Dispute Uphold notification of improper payment to HMS

HMS will provide the outcome of the Second Level Dispute review in writing via the Second Level Uphold or Second Level Overturn letter.

All First and Second Level Dispute outcomes will be shared with MDwise.

# Provider Resources

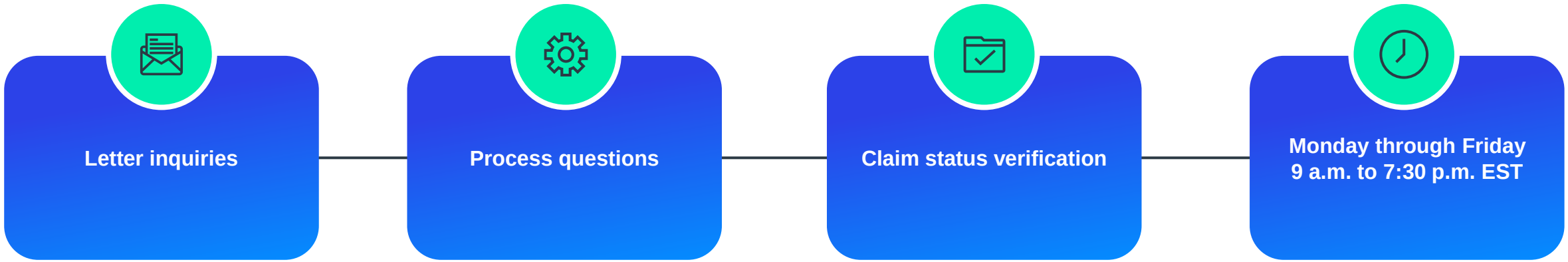
# Open Communication

- 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

**Provider Portal site:** **https://hmsportal.hms.com/**

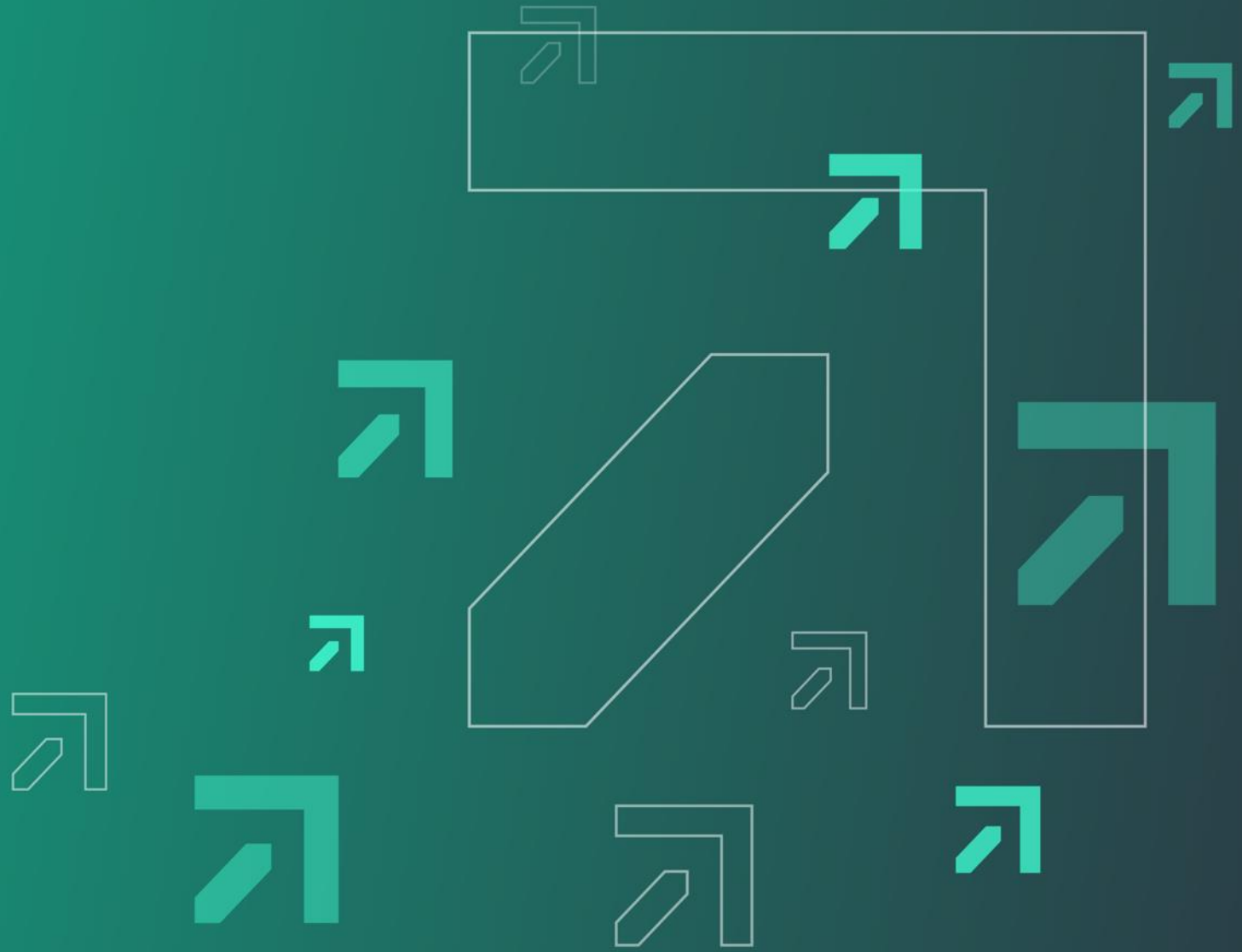
**HMS Provider Relations Line:** **855-714-0977**



# Education and Outreach

| Format | Purpose | Method | Contact Initiator | Recipient |
|---|---|---|---|---|
| **Provider Notification** | Provide advance notice of audit activities and provider webinar | MDwise Website | MDwise | Provider |
| **Provider Webinar** | Provide an overview of the audit and review process | Teams Meeting | MDwise HMS | Provider |
| **Telephone Calls / Email** | Answer inquiries related to audit process, claims status, medical documentation receipt, HMS provider portal | Telephone Email | HMS | Provider |
| **HMS Provider Portal** | Allows providers to manage medical records with HMS: submission, audit, improper payment notification letters, and disputes | Web-based | HMS | Provider |

# Thank you





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