Medicare Medical Review Overview

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Disclaimer

• This resource is not a legal document.
• This presentation was prepared as a tool to assist providers.
• This presentation was current at the time it was created.
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Objectives

- Define the purpose of Medical Review (MR)
- Define MR Activities
- Review the ADR process and timeline for medical record submission
- Define the MR validation process and timeline for review
- Review the Appeals process

Program Integrity and Provider Compliance

- CMS guidance and instruction is provided in the Program Integrity Manual – Publication 100-08
- Addressing improper payments in the Medicare program is a top priority with CMS.
- CMS contracts with several contractors to fight improper payments:
  - Comprehensive Error Rate Testing (CERT)
  - Medicare Administrative Contractors (MACs)
  - Recovery Auditors (RAs)
  - Specialty Medical Review Contractors (SMRC)
  - Zone Program Integrity Contractors (ZPIC)
Medical Review Goal

Protect the Medicare Trust Fund against erroneous claims

Pay legitimate providers for covered services appropriately rendered to beneficiaries

MR Purpose

• The Medical Review (MR) Program is designed to provide an organized method of implementing Medicare policies and guidelines. CMS automates this process when possible, but medical record review may be required to determine the medical necessity of certain Medicare services.
MR Activities

Prepayment review
Occurs when edits in the Fiscal Intermediary Standard System (FISS) or the Multi-Carrier System (MCS) suspend a claim for medical review before the claim is paid.

Postpayment Review
Occurs when paid/processed claims are selected for review. These reviews are not performed by Cahaba at the present time.

MR Activities/Prepay Edits

Prepayment edits may include:

Widespread Edits - developed based on data analysis that identifies provider billing practices that may pose a risk to the Medicare program. All providers are subject to a widespread edit when the claim meets the parameters of the edit. A notification article is posted to the Cahaba Website to notify providers of initiation of a widespread review.

Provider Specific Edits - suspend an individual provider's claims based on identification of billing practices that pose a risk to the Medicare program. Providers are notified in writing prior to being placed on a “Provider Specific Review.”
MR Activities/Prepay Edits

Widespread and Provider Specific Review may be classified as a PROBE or TARGETED REVIEW.

Probe Reviews

As potential problems are identified through data analysis, a small "probe" sample of claims may be selected in order to validate a possible billing error.

- Provider Specific – 20-40 claims
- Service Specific – 100 claims
Targeted Review

- When the provider or service specific probe reviews are complete, providers may be placed on **Targeted Review** if a high incidence of inappropriate billing is found. The provider is notified by letter before initiation of a Targeted Review. Widespread probe results are posted on Cahaba’s website.

- Targeted review edits simply pull a percentage of any claims billed by a provider. At the end of each quarter, individual provider error rates are calculated and a provider notification letter is sent. A notification article is posted to the Cahaba Website for service-specific issues (Widespread Targeted Review).

Edit Implementation and ADRs

After edit logic is set up in FISS/MCS (claims processing systems), the Additional Documentation Requests (ADRs) are generated by the system

- MCS for Part B – hardcopy letters are mailed to the providers
- FISS for Part A – on-line access (preferred) or hardcopy letter mailed to the facility
Submission of Documentation

- Provide **all** documentation as requested in the ADR
  - Mail, Fax, CD, esMD
- Submit medical records within 45 days to avoid system denial for no records. The claim will be denied on day 46.
- Include a copy of the ADR letter as the first document – place it on top.

Medical Review Validation

- Complete the review within 30 days of receipt
- Enter decision and rationale in FISS or MCS
- Determine the error rate
  - Dollar amount billed in error/Dollar amount of charges medically reviewed
- Communicate results
  - Provider letter for Provider-specific reviews
  - Results article for Service-specific
- Education
Education

For educational needs/questions related to MR activities, contact
MREducationPartA@cahabagba.com
OR
MREducationPartB@cahabagba.com

Current Prepay Medical Review Log - Part A

Current Prepayment Medical Review Log

The table below provides you with a list of the most current prepayment reviews being conducted by the Part A Medical Review Department. This list is not an all-inclusive list.

<table>
<thead>
<tr>
<th>Medical Review</th>
<th>Bill Type</th>
<th>Edi Number(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Retail Facility</td>
<td>11X</td>
<td>01760 - Alabama</td>
</tr>
<tr>
<td></td>
<td></td>
<td>31340 - Georgia</td>
</tr>
<tr>
<td></td>
<td></td>
<td>52020 - Tennessee</td>
</tr>
<tr>
<td>Inpatient Retail A0231-A0264</td>
<td>11X</td>
<td>01770 - Alabama</td>
</tr>
<tr>
<td></td>
<td></td>
<td>31340 - Georgia</td>
</tr>
</tbody>
</table>
Appeals/Redeterminations

• If a provider disagrees with the initial MR determination, an Appeal/Redetermination may be submitted.
• A “Redetermination” is the first level of appeal, which is an independent re-examination of the claim and its supporting documentation by Medicare staff who were not involved in the initial claim decision.
• To initiate a redetermination, access the CMS-20027, Medicare Redetermination Request Form, the Cahaba Medicare A Redetermination Request form, or submit a written request.
**Appeals/Redeterminations**

- The redetermination request must be submitted within 120 calendar days from the date of receipt of the initial determination notice. The Remittance Advice (RA), Electronic Remittance Advice (ERA), or the Medicare Summary Notice (MSN) is considered an initial determination notice for timeliness.

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**Appeals Levels and Deadlines**

<table>
<thead>
<tr>
<th>Level</th>
<th>AIC – Effective 1/1/2017</th>
<th>Deadline to Request</th>
<th>Processing Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>I – Redetermination</td>
<td>No minimum</td>
<td>Within 120 days of RA/ERA</td>
<td>60 days</td>
</tr>
<tr>
<td>II – Reconsideration</td>
<td>No minimum</td>
<td>Within 180 days of redetermination notice</td>
<td>60 days</td>
</tr>
<tr>
<td>III-Administrative Law Judge</td>
<td>At least $160</td>
<td>Within 60 days of reconsideration notice</td>
<td>90 days</td>
</tr>
<tr>
<td>IV-Appeals Council Review</td>
<td>No minimum</td>
<td>Within 60 days of ALJ hearing notice</td>
<td>90 days</td>
</tr>
<tr>
<td>V-Judicial Review</td>
<td>At least $1,560</td>
<td>Within 60 days of Appeal Council notice</td>
<td>None</td>
</tr>
</tbody>
</table>
Resources

MR Guidance
CMS Manual, Publication 100-08 (Program Integrity Manual)

Redeterminations:
Medicare Claims Processing Manual (Pub 100-04) Chapter 29, Section 310

Questions?

Please limit your questions to the Medical Review Process