The Medical Review and Appeals Show

Presented by
Cahaba Government Benefit Administrators
Provider Outreach and Education
March 25, 2010

Showing Today:

Take One!
Medical Review Program

Take Two!
Appeals Process

Take Three!
What Does It Take?
  ○ Know the Script
  ○ Write the Script
  ○ Sign the Script
Disclaimer

This resource is not a legal document. This presentation was prepared as a tool to assist our providers. This presentation was current at the time it was created. Although, every reasonable effort has been made to assure accurate information, responsibility for documentation and correct claims submission lies with the provider of services. Reproduction of this material for profit is prohibited.

Medical Review (MR) Program

The MR program is designed to promote a structured approach in the interpretation and implementation of Medicare policy. CMS makes it a priority to automate the MR process; however it may require the evaluation of medical records to determine the medical necessity of Medicare claims.

Program Integrity Manual Pub. 100-08- Chapter: 1
Why is a Medical Record Important?

- Records pertinent facts, findings, and observations about a patient's health history, including past and present illnesses, examinations, tests, treatments, and outcomes.
- Serves as a legal document to verify care was provided.
- Auditing agencies may use to verify supporting documentation of services provided.

Goal of Medical Review

- The goal of the MR program is to reduce payment error by identifying and addressing billing errors concerning coverage and coding made by providers. To achieve the goal of the MR program, contractors:
  - Analysis of data
  - Action to prevent and/or address the identified provider errors
  - Work on reducing the paid claims error rate
  - Publish Local Coverage Determinations (LCD) to provide guidance to the public and medical community

© Program Integrity Manual Pub. 100-08- Chapter: 3
Coverage Determinations

**Policy:** Medicare policies are used by the contractor to apply Medicare coverage guidelines. These policies are generally divided into National Coverage Determinations (NCDs), coverage provisions in interpretive manuals, and Local Coverage Determinations (LCDs).

- **NCDs** are developed by the Centers for Medicare & Medicaid Services (CMS) to describe the circumstances for Medicare coverage nationwide for a specific medical service procedure or device.

- **LCDs** are decisions by a contractor whether to cover a particular service on a contractor wide basis in accordance with Section 1862 (a)(1)(A) of the Social Security Act (i.e. reasonable and necessary).

Cahaba GBA Coverage Link:
- www.cahabagba.com/part_b/policies_medical_review/lcd_active.htm

Progressive Corrective Action (PCA)

- The Medical Review unit reviews data and may conduct widespread and provider specific probes.

- The probes are conducted as outlined in the Progressive Corrective Action (PCA) instructions outlined in the Program Integrity Manual: chapter 3.11

Program Integrity Manual Pub. 100-08- Chapter: 2 – 3.11
Progressive Corrective Action (PCA)

What Are Probe Reviews?

- Contractors may examine 20–40 claims per provider for provider-specific problems.
- Contractors also conduct widespread probe reviews (involving approximately 100 claims from multiple providers) when a larger problem, such as a spike in billing for a specific procedure, is identified.
- In either type of review, providers are notified that a probe review is being conducted and are asked to provide medical documentation for the claim(s) in question.
- Medical records are reviewed and providers are notified of the results.
Appeals Process

- Five Levels of Appeals
  - Redetermination
  - Reconsideration
  - Administrative Law Judge (ALJ) Hearing
  - Departmental Appeals Board (DAB) Review
  - Federal District Court Review

- Each level must be completed before proceeding to the next level of appeal.
- Appeal accepted once an initial claim determination has been made.

Appeals Process Tips

- Submit supporting additional medical record documentation for review.
- Make sure your records are signed.
- Make sure you include the following 5 points in your request:
  - Beneficiary Name
  - Beneficiary HICN
  - Date of service and description of service (ex. provider remittance with information)
  - Printed name and signature
  - 120 days plus 5 mailing days is the time to request an appeal from initial determination
- Do not include Post-IT notes when requesting a Redetermination.
- Send your Appeal request to the correct Appeal address serving your state: [www.cahabagba.com/part_b/claims/appeals_process.htm](http://www.cahabagba.com/part_b/claims/appeals_process.htm)
- Where Not to Send the Appeal Request: Addresses other than the Appeal address.
- Simple correction, call the Reopening line or submit in writing on a reopening form to the correct address for reopening.
Comprehensive Error Rate Testing

CERT Goals

- Protect the Medicare trust fund
- Measure the extent to which providers are submitting claims correctly.
- Measure the extent to which the Medicare program is paying claims correctly.

- Stamp signatures are not acceptable.
- Documentation can be submitted electronically on a CD, mailed or faxed.

For more information, visit these websites:
  - [www.cms.hhs.gov/CERT/](http://www.cms.hhs.gov/CERT/)
  - [www.certcdc.com/certproviderportal/](http://www.certcdc.com/certproviderportal/)
Medical Record Documentation

“If It Is Not Documented, It’s Not Done”

- Complete and legible record
- Documentation for each encounter should include:
  - Reason for the encounter, relevant history, exam and prior diagnostic test results; reports if applicable;
  - Assessment, clinical impression;
  - Plan for care; and
  - Medicare requires that services provided/ordered be authenticated by the author.

Past & present diagnoses should be accessible to the treating and/or consulting physician;

Identify health risk factors;

Patient's progress, response to treatment, changes in treatment or revisions in diagnoses should be documented; and

Document any revisions to the plan of treatment.

Services billed should be supported by medical record documentation.

Correctly coded services.
**What's New: Signature Requirements**

- March 16, 2010: Transmittal 327: Change Request 6698
- Effective Date: March 1, 2010
- Implementation Date: April 16, 2010

For medical review purposes, Medicare requires that services provided/ordered be authenticated by the author. The method used shall be a handwritten or an electronic signature. Stamp signatures are not acceptable.

**Signature Requirements: Tips**

- Sign your medical records:
  - Legible handwritten or electronically signed.
  - **Do not** use a stamp signature.

- The reviewers look for documentation of intent in the physician's progress/office notes (e.g. signed progress note that a diagnostic test was performed).

- Make sure handwritten or electronic office records submitted for review are signed; check with vendor to assist with printing E-record with signature, if needed.

- Physician's must countersign notes, when applicable (CRNP, PA, etc., all working under physician direction).

- Facsimile of original written or electronic signatures are acceptable for the certifications of terminal illness for hospice.
**Signatures: Ambulance Providers**

- CMS Beneficiary Signature Requirements
- Medicare Benefit Policy Manual – Chapter 10: 20.1.2
- There must be an appropriate beneficiary signature for accepting assignment and submitting a claim.
- Documented medical necessity for transports.
- Submit medical records for review when requested.

**Signature Requirements**

**Acceptable Signatures:**

Refer to Change Request 6698 for a variety of examples for signature requirements (see signature reference chart in Change Request; link on reference slide 22).

March 16, 2010: Transmittal 327: Change Request 6698
References

Cahaba GBA Home Page: www.cahabagba.com
Cahaba GBA Listserv: www.cahabagba.com/email_service.htm
Appeals Process: www.cahabagba.com/part_b/claims/appeals_process.htm
Part B Clerical Error Reopening:
   www.cahabagba.com/part_b/claims/clerical_error_reopen.htm
CMS Home Page: www.cms.hhs.gov
Program Integrity Manual Pub. 100-08- Chapter: 3.4.1.1 - B: Documentation Specifications for Areas Selected for Prepayment or Post payment MR:

Provider Contact Centers:
• Alabama, Georgia and Tennessee Providers: 1-877-567-7271
• Mississippi Providers: 1-866-419-9454

New Resources

Change Request 6698: Signature Guidelines for Medical Review Purposes:
   Effective Date: March 1, 2010
   Implementation Date: April 16, 2010

Evaluation and Management Services Information Center:
   www.cahabagba.com/part_b/education_and_outreach/evaluation_and_management_services/index.htm

Resource Center for Providers:
   www.cahabagba.com/part_b/education_and_outreach/resource_center.htm

Cahaba University – step 5 on Resource Center page

CMS Media Center: www.cms.hhs.gov/newmedia/
   CMS YouTube channel and two Twitter accounts
Questions?

Please complete your evaluations and post-test assessment.

FAX to (205) 220–1526

The End!

Thanks for Attending!