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Director of Education and Compliance



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Quality Assurance UPDATE

The Medicare Medical Review Program Mary Pidich, VP, Quality Assurance

What is Medical Review?

The Centers for Medicare and Medicaid Services (CMS) is required by the Social Security Act to ensure that payment is made only for those medical services that are reasonable and necessary. To meet this requirement, CMS contracts with Carriers, Fiscal Intermediaries (FIs) and Program Safeguard Contractors (PSCs) to perform analysis of claim data to identify atypical billing. These entities are referred to as Medicare "Contractors". After data analysis (e.g., ICD-9 codes, number of visits or units billed, dollars billed), contractors must verify if billing problems exist. The severity of the problem will determine whether the Contractor performs a Medical Review (MR). MR is defined as a review of claims to determine whether services provided are medically reasonable and necessary.

What are National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs)?

NCDs and LCDs help providers avoid billing Medicare for items and services that are not covered or are coded incorrectly. Contractors develop LCDs in the absence of national policy when data analysis or other information indicates that coverage guidance is needed by the medical community. LCDs are formal statements developed by Contractors to:

- Outline coverage criteria;
- Define medical necessity; and
- Provide references upon which a policy is based.

Providers should know the name of their Contractor (i.e., Highmark, National Government Services, Cahaba, Mutual of Omaha, etc.) and should use their Contractor LCDs for coverage guidance.

How can I get a copy of my Contractor's LCD?

Contractor LCDs are posted on the Contractor's website under "Medical Policy". A list of Contractors is provided in this newsletter.

What is an Additional Development Request (ADR)

An ADR occurs when a Contractor requests a copy of medical records on Medicare A and Medicare B claims before a final payment determination is made.

What are Probe Reviews?

Under probe reviews, Contractors may examine 20-40 claims per provider for specific problems. Contractors also conduct widespread probe reviews involving approximately 100 claims from multiple providers when a larger problem, such as when a spike in billing for a specific procedure is identified.

What happens after a Probe Review?

When probe reviews verify that an error exists, the Contractor classifies the severity of the problem as minor, moderate or significant. All levels of error will require that providers receive education on proper billing procedures and the collection of money from claims that are denied for payment.

What Corrective Actions May Result from Probe Review Findings?

The following types of corrective actions can result from probe review findings:

- Education - The Contractor is required to inform the provider of appropriate billing procedures
- Prepayment Review - Medical review of a claim occurs prior to payment

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MEDICARE APPEAL PROCESS

1. Provider Bills Medicare (Fiscal Intermediary (FI) or carrier) for Services Rendered

"Clean Claim" means claim is paid in full w/o review of records

Additional Development Request - 30 days to respond with requested records

2. Additional Development Request

After review of records claim is paid in full

Claim is partially or fully denied - Initial Determination

3. Appeal Level - REDETERMINATION

Provider/Beneficiary requests an appeal with the FI or Carrier within 120 days from date of notice of the Initial Determination Letter

After review of records claim is paid in full

or

Claim is partially or fully denied - Initial Determination

4. Appeal Level - RECONSIDERATION

Provider/Beneficiary requests appeal within 180 days from the date of Redetermination decision letter

After review of the appeal, the claim is paid in full

or

Redeterminator decision partially or fully upheld

5. Appeal Level - ADMINISTRATIVE LAW JUDGE (ALJ) HEARING

(Amount in controversy must be at least \$110)

Provider/Beneficiary requests an ALJ hearing within 60 days of the Reconsideration decision letter

After hearing completion, the claim is paid in full

or

Reconsideration decision partially or fully upheld

6. Appeal Level - DEPARTMENT OF APPEALS BOARD (DAB) REVIEW

Provider/Beneficiary requests a DAB Hearing within 60 days of the ALJ hearing decision letter

After hearing completion, the claim is paid in full

or

ALJ hearing decision partially or fully upheld

7. Appeal Level - FEDERAL COURT REVIEW

(Amount in controversy must be at least \$1,130)

Provider/Beneficiary requests a Federal Court review within 60 days of the DAB review decision letter

After hearing completion, the claim is paid in full

or

DAB hearing decision partially or fully upheld

The Medicare Medical Review Program

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- Postpayment Review – Medical review of a claim occurs after payment has been made

What are the Rights of the Provider after Medical Review, including Probe Reviews?

Providers have the right to be educated on how to bill correctly and have questions answered in a timely manner. In addition, once an initial claim determination is made providers have the right to appeal the Contractor's decision.

What is the Medicare Appeals Process?

When providers do not agree with the initial claim determination by a Contractor they may appeal the decision. There are five levels in the Medicare Part A and Part B appeals process. The levels, listed in order, are:

- Redetermination by the FI or Carrier
- Reconsideration by the Qualified Independent Contractor (QIC)
- Hearing by an Administrative Law Judge (ALJ)
- Review by the Appeals Council
- Judicial review in the U.S. District Court

FOCUS on: CLEAN CLAIMS

Denials management begins with the prevention of denied Medicare claims. The claim for Part A services (room and board plus ancillary services) or Part B (ancillary services) must be submitted to the Medicare Contractor with accurate information to be processed without delay. A "clean" claim passes all Contractor edits and is processed without the need for contacting the provider, supplier, physician or beneficiary. Contractors are required to process a "clean" claim within 30 days of receipt. Monthly review of clinical and billing documentation should reduce any technical problems with the claim that could result in (ADRs).

What can you do to avoid ADRs?

1. Medical and treatment diagnosis codes for therapy must be on the billing form sent to the Contractor for pay-

ment. Supply your billing office with accurate and appropriate ICD-9 codes.

2. Provide accurate onset, start of care, certification and recertification dates to the billing office for all Part B claims.
3. Refer to the Contractor's Local Coverage Determination for coverage and documentation guidelines.

FOCUS on: ADDITIONAL DEVELOPMENT REQUEST

Claims that are not paid upon receipt by the Contractor may be suspended until additional information is received to support the filed claim. The provider must respond to the Contractor request for medical records within 30 days. Failure to return the records in a timely manner will result in denied payment for the claim. When the Contractor receives the requested information, a review of the documentation determines if there is support for the services billed. If the Contractor decides that the documentation does not support the services billed, the claim is denied in part or in full.

A "clean" claim passes all Contractor edits and is processed without the need for contacting the provider, supplier, physician or beneficiary.

What do you do when you receive an ADR?

1. The rehabilitation staff designee checks the therapy information for completeness and accuracy and records the review on the ADR Review Form. (Use the Long-Term Care version for skilled nursing facility ADRs and the AC Outpatient version for hospital or physician office ADRs).
2. A copy of the reviewed information is retained at the therapy department for future reference.
3. The business office manager mails the information out and regularly checks the status of the claims.
4. The rehabilitation staff designee reports the ADR to the divisional office designee for tracking purposes and follows the status of the claim at least biweekly with the business office.
5. Contractor initial determinations are reported to the divisional office designee who notes this information on the appropriate tracking form.

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The Deadline for the Next Issue of "On D.E.C!" will be September 15, 2007
Please forward all articles to Holly Hester: hhester@enduracare.com