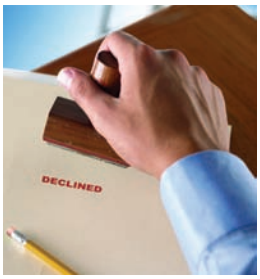
The Medicare Medical Review Program

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Medicare Learning Network

OVERVIEW



The Centers for Medicare & 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 data analysis of claim data to identify atypical billing. These entities are referred to as Medicare "Contractors". After data analysis, Contractors must verify if billing problems exist through probe reviews. They then determine the severity of the problem and the appropriate corrective action. The severity of the problem will determine whether the Contractor performs Medical Review (MR). This document gives a general overview of the MR Program to assist Medicare Part B providers (defined as physicians and suppliers) in gaining a better understanding of their role in the MR process.

What Is MR?

MR is an important part of the Medicare Integrity Program that requires Contractors to verify inappropriate billing and to develop interventions to correct the problem. MR is defined as a review of claims to determine whether services provided are medically reasonable and necessary, as well as to follow-up on the effectiveness of previous corrective actions.

What Are the Objectives of the MR Program?

The goal of the MR Program is to reduce the payment error rate by identifying and addressing billing errors concerning coverage and coding made by providers. The objectives of the program include:

- Identifying and preventing inappropriate Medicare payments.
- Using national and local data to identify potential problems that present the most risk to the Medicare Program.
- Educating providers on appropriate billing practices.
- Ensuring the appropriate payment of Medicare-covered services.

What Are the Benefits of MR for Providers?

MR initiatives are designed to ensure that Medicare claims are paid correctly. MR offers many benefits to providers while helping to maintain the integrity of the Medicare Program. These benefits include:

- **Reduced Medicare claims payment error rate**—The MR Program identifies and addresses billing errors concerning coverage and coding made by providers, thus reducing the overall claims payment error rate.
- **Decreased denials**—Knowledge of the appropriate claims guidelines may result in a reduction in filing errors and an increase in timely payments.
- **Increased educational opportunities**—Medicare provides education on all claims that are denied through MR. Contractors also issue articles and other informational materials. The educational processes provided by Medicare help providers know what to expect when a claim is submitted to Medicare for payment.

COVERAGE DECISIONS

National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs) help providers avoid billing Medicare for items and services that are not covered or are coded incorrectly.

What Are NCDs and LCDs?

Providers should be aware of all coverage decisions before submitting claims. CMS establishes NCDs to specify the circumstances under which Medicare covers specific medical items, services, treatments, procedures, or technologies. The ***National Coverage Determinations Manual***, available in the CMS Online Manual System at www.cms.hhs.gov/manuals addresses all of the above services for which coverage decisions have been made.

LCDs are formal statements developed by Contractors to:

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

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.

THE MR PROCESS

How Are Providers Selected for MR?

Providers may be selected for MR when atypical billing patterns are identified, or when a particular kind of problem (e.g., errors in billing a specific type of service) is identified.

What Claim Types Are Subject to MR?

Contractors may perform MR functions for all claims appropriately submitted to a Carrier, Durable Medical Equipment Regional Carrier (DMERC), FI, or Regional Home Health Intermediary (RHHI). Since Quality Improvement Organizations (QIOs) perform reviews, Contractors do not perform MR functions for: (1) Acute Care Inpatient Hospital Prospective Payment System (PPS) Diagnosis Related Group (DRG) claims or (2) Long Term Care Hospital (LTCH) claims.

What Determines the Need for MR?

Through data analysis and evaluation of other information (e.g., complaints), suspected billing problems are identified by Contractors. Contractors then use Progressive Corrective Action (PCA) to ensure that MR activities are targeted at identified problem areas and that the corrective actions imposed are appropriate for the severity of the problem. Before assigning significant resources to examine claims identified as potential problems, Contractors must validate claim errors through the use of probe reviews.

What Are Probe Reviews?

Under 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. Providers are notified of the results of the probe review.

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. Contractors may classify the severity of the error by determining the provider-specific error rate (number of claims paid in error), dollar amounts improperly paid, and past billing history. All levels of error will require that providers receive education on proper billing procedures and the collection of money from claims paid in error. Contractors will then respond to the billing problem(s) as appropriate for the level of severity, and determine what steps need to be taken to correct the problem(s).

Does MR Require Review of Medical Records?

Most MR does not require review of medical records. Often, MR is conducted by simply examining the claim itself, usually in an automated method. If more information is needed, the Contractor also reviews attachments [e.g., Certificates of Medical Necessity (CMNs)] and/or patient history files.

In a small percentage of cases, the Contractor will request access to medical records to confirm that the services rendered are reflected on the claim, coded correctly, and covered by Medicare.

CORRECTIVE ACTION

Validating initial findings from MR evaluations may require additional reviews resulting in corrective action. To assist in MR evaluations, CMS designed MR PCA. PCA ensures that MR activity is targeted at identified problem areas and that imposed corrective actions are appropriate for the severity of the infraction of Medicare rules and regulations.

What Corrective Actions May Result from MR?

The following types of corrective actions can result from MR:

- **Education**—Problems detected at minor, moderate, or significant levels will require the Contractor to inform the provider of appropriate billing procedures.
- **Prepayment review**—Prepayment review consists of MR of a claim prior to payment.
- **Postpayment review**—Postpayment review involves MR of a claim after payment has been made.

What Is Prepayment and Postpayment Review?

Providers with identified problems submitting correct claims may be placed on "prepayment review", in which a percentage of their claims are subjected to MR before payment can be authorized. Once providers have re-established the practice of billing correctly, they are removed from prepayment review.

Postpayment review is generally performed by using Statistically Valid Sampling. Sampling allows an underpayment or overpayment (if one exists) to be estimated without requesting all records on all claims from providers. This reduces the administrative burden for Medicare and costs for both Medicare and providers.

Both prepayment and postpayment reviews may require providers to submit medical records. When

medical records are requested, the provider must submit them within the specified timeframe or the claim will be denied.

Provider feedback and education regarding MR findings is an essential part of all corrective actions. Feedback and education further ensure proper billing practices.

THE PROVIDER'S ROLE

How Can Providers Assist in the MR Process?

The purpose of the MR process is to make sure claims are paid correctly. Providers can take certain measures to help meet this goal:

- Review and read all Contractor provider publications and LCDs and be aware of coverage requirements.
- Make sure that office staff and billing vendors are familiar with claim filing rules.
- Check records against billed claims.
- Create an educational awareness campaign for Medicare patients that explains any specific coverage limitations or medical necessity requirements for those services provided.
- Perform mock record audits to ensure documentation reflects the requirements outlined in the LCD.

How Can Providers Create Documentation that Assists in MR?

To perform effective MR of services, Contractors may request that the provider furnish documentation to support the services under review. The provider should keep in mind the following points:

- Documentation must be provided, when requested, for every service selected for MR;
- Documentation should demonstrate that the patient's condition warranted the type and amount of services provided;
- Documentation must be legible, even if it is dictated or transcribed; and
- Each service must be coded correctly.

PROVIDER RIGHTS

What Are the Rights of the Provider During MR?

The provider has the right, following MR, to be educated on how to bill correctly and to have questions answered in a timely manner. The provider also has the right to appeal determinations, as long as the appeals are filed in accordance with regulations governing that process. For more information on the appeals process, see the ***Medicare Appeals Process Brochure*** available on the Medicare Learning Network (MLN) at www.cms.hhs.gov/MLNProducts/ on the Web.

WHERE CAN I FIND MORE INFORMATION?

Please visit the following websites for more information on the MR Program:

MR Home Page
www.cms.hhs.gov/MedicalReviewProcess/

The Medicare Medical Review Program Home Page provides a brief introduction to the MR Program and includes links to the ***Medicare Program Integrity Manual***, additional information on LCDs, and available technical assistance.

CMS Online Manual System
www.cms.hhs.gov/manuals/IOM/List.asp

The CMS Online Manual System includes the ***Medicare Program Integrity Manual***, which contains additional information regarding the MR Program, including LCD, Benefit Integrity (BI), and Local Provider Education and Training (LPET) Programs. It also includes the ***National Coverage Determinations Manual***, which describes Medicare coverage policies for specific medical items, services, and technologies.

Medicare Coverage Database
www.cms.hhs.gov/mcd/indexes.asp

The Medicare Coverage Database contains all national and local coverage policies, as well as national articles.

Medicare Contractors Toll-free Customer Service
www.cms.hhs.gov/contacts/incardir.asp

Providers who have questions related to the MR Program should contact their local Medicare Contractor's toll-free customer service number for assistance.

The Medicare Learning Network

The Medicare Learning Network (MLN) is the brand name for official CMS educational products and information for Medicare fee-for-service providers. For additional information visit the Medicare Learning Network's web page at www.cms.hhs.gov/MLNGenInfo on the CMS website.

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