TO: ALL PROVIDERS

FROM: CAREFIRST OF MARYLAND, INC., MEDICARE PART A

DATE: JULY 27, 2004

SUBJECT: MEDICAL REVIEW PROCESSES

Medical Review is one of the Medicare Program Integrity Units. The primary goal of Program Integrity is to safeguard the Medicare Trust Fund by ensuring that claims billed to Medicare are paid correctly. Medical Review efforts are directed to those areas where there is the greatest risk of inappropriate program payment. It is the goal of Medical Review to ensure that the right amount is paid for covered services which are medically necessary and rendered to eligible beneficiaries by legitimate providers. This goal is accomplished through review of claims utilizing national coverage guidelines, medical knowledge and judgment and the development and implementation of Local Coverage Determinations.

LCD DEVELOPMENT PROCESS

Local Coverage Determination (LCD) is an administrative and educational tool to assist providers, physicians, and suppliers in submitting correct claims for payment. The process for developing the LCD includes developing draft LCDS based on review of medical literature and the contractor's understanding of local practice. In addition, contractors solicit comments from the medical community. Medicare contractors permit interested parties to submit scientific, evidence-based information, professional consensus opinions, or any other relevant information during the draft process.

After a draft LCD has been commented on and revised, it is published in its final form. Subsequently, the LCD Reconsideration process allows an opportunity to request modifications to the policy. The contractor may consider requests from any interested party receiving care or residing in a contractor's jurisdiction.

Requests must be submitted in writing, and must identify the language that the requestor wants added to or deleted from an LCD. Requests must include a justification supported by new evidence, which may materially affect the LCD's content or basis. Copies of published evidence must be included. Any request for LCD reconsideration that, in the judgment of the contractor, does not meet these criteria is invalid.

Within 30 days of the day the request is received, the contractor must determine whether the request is valid or invalid. If the request is invalid, the contractor must respond, in writing, to the requestor explaining why the request was invalid. Within 90 days of the day a valid request was received, the contractor must make a final LCD reconsideration decision and notify the requestor of the decision and its rationale. Decision options include retiring the policy, no revision, revision to a more restrictive policy, or revision to a less restrictive policy.

Requests may be mailed or faxed to:

Patricia Neal, RN Utilization Review Specialist
CareFirst of MD, INC., Medicare Part A Intermediary
1946 Greenspring Drive, TBP-11
Timonium, MD 21093-4141
FAX: 410-561-7951

PREPAYMENT REVIEW

Prepayment review is divided into three distinct types of review. These three types are defined as:

- **Automated Review** This review does not involve any human intervention whatsoever. It occurs when a claim/line passes through the claims processing system and is denied in whole or in part because the service(s) is noncovered or incorrectly coded. Automated review parameters are designed utilizing the Local Coverage Determinations.
- **Routine Manual Review** Routine review requires hands on review of the claim and/or any attachment or codes submitted by the provider, excluding the review of complete medical records, for the purpose of preventing payments of noncovered or incorrectly coded services. This review includes any existing documentation such as the claims history file or policy documentation.
- **Complex Medical Review** Complex review goes beyond the routine manual review process and includes review by a nurse of the medical records that are requested by the Intermediary. This review of medical documentation is for the purpose of preventing payment for noncovered or incorrectly coded service.

ADDITIONAL DEVELOPMENT REQUESTS (ADRs)

During the prepayment review process, a claim will often hit an edit placed in the processing system by Medical Review. This edit will result in the automatic generation of an ADR letter and the claim will suspend in the system pending receipt and complex review of the medical records. Providers have 30 days from the date of the letter to submit the requested medical information. The ADR letter specifically lists the medical information that must be returned for reviewing the pending claim. A copy of the ADR letter must be attached to the front of the medical record sent in by the provider. Failure to submit all of the medical information as requested may result in a partial or full denial of charges. If the medical records are not received within 45 days, the claim will be automatically denied by the system. The failure to submit requested medical records within 45 days will be designated by reason code 56900. Once the claim receives a 56900 denial, the provider's only recourse is to request an appeal of the denial.

Note: Thirty days are allocated for provider processes in submitting the requested record. The remaining fifteen days are allowed for the FI's processing requirements (i.e. mail days required for receipt of the ADR letter, routing the medical records to the correct unit from the mail room, etc.). Providers should make every effort to submit the records within 30 days.

IMPORTANT DO'S AND DON'TS

- Do attach the ADR letter to the front of the medical record
- Do include ALL the medical information as requested on the ADR letter
- Do submit the medical records per request within 30 days of receipt of ADR letter
- Do <u>not</u> attempt to expedite claims processing by sending in the medical record prior to receiving the ADR letter based on information in the claims processing system

POST PAY PROBE REVIEWS

CareFirst of MD, Inc. Medicare Part A Medical Review conducts medical record reviews on a postpayment basis. A specific group of medical records will be requested; the review of these records is classified as a 'Probe Review'. The probe review process is a data driven process. Paid claims billing data is analyzed and providers are selected for review based on identified aberrancies in comparison with other providers billing the same service(s). A random sample of

20-40 claims is selected from the provider's paid claims data for a specified billing period. In the event of a general probe that is service specific rather than provider specific, a sample of 100 claims will be selected.

Once a provider has been selected for a post pay probe review, a letter is mailed to the provider notifying them that they have been selected for a post-payment probe review. The Special Post-Payment Probe Review Letter indicates the reason for review and includes a list of the claims that have been selected for review. The letter informs the provider that the medical records for the selected claims must be returned to the Fiscal Intermediary within 30 days from the date of the letter. Those claims for which no medical records are received will be reopened for denial due to lack of receipt of medical records.

Once the medical records are received for a specific probe review, the review is assigned to a Probe Nurse. Per CMS standards, Medical Review must complete the reviews within 60 days of record receipt. The probe nurse reviews the claims based on coverage criteria available for the specific service. These sources for criteria may include Local Coverage Determinations (LCDs), National Coverage Determinations (NCDs), Medicare Bulletins, Program Memorandums, one-time notifications, as well as specific policies and desk procedures for the type of review.

Once the probe nurse completes the probe review, an error rate is calculated. This error rate is calculated by dividing the total amount of billed charges (associated with the service under review) denied by the total amount of billed charges (associated with the service under review).

Once the denial statistics are obtained, the Probe Nurse develops a "Probe Summary Letter" which is mailed to the attention of the Provider Contact.

This letter outlines the findings of the review by types of denials, an error rate percent, and recommendations for correcting identified errors. Included with the letter is an attachment with a breakdown for each claim that sustained an error.

Note: The FI has requested that each facility provide a contact phone number for a designated Provider Point of Contact. The Provider Point of Contact must be someone who has the ability to identify appropriate key personnel (based upon the service under review) for the education and internal planning to resolve the identified issues. In general, the FI has found that the facility Compliance Officer is well suited for this process.

For those providers whose error rate on initial probe review is 10% or less, the Probe Summary Letter commends the provider for the low error rate and informs them that the review of the particular service has been discontinued. Those providers with a greater than 10% error rate on the initial probe review are subjected to a re-probe review after one on one provider education has taken place. This education is usually done by way of a telephone conference call. For those providers with greater than 24% error rate, the usual action is for the provider to be placed on a percentage of prepay review.

ADVANCE BENEFICIARY NOTICE (ABN)

The beneficiary should be notified that a service is non-covered prior to the service being rendered. This notification must be signed and dated by the beneficiary at the time it is received. The ABN should be very specific as to the non-covered services and the effective date of non-coverage.

It is the responsibility of the provider to maintain current knowledge of Medicare coverage guidelines, Local Coverage Determinations (LCDs), and billing guidelines. Once the

determination has been made that a service is non-covered and the beneficiary has signed the ABN, the charges may be billed to the beneficiary.

Routinely requesting the beneficiary to sign a letter of non-coverage just in case Medicare does not reimburse for the service is unacceptable. Once a pattern of administering routine ABNs or non specific ABNs is identified, Medicare does not acknowledge the waiver of liability and the provider is held responsible for any denied charges.

PHYSICIAN ORDERS

Medicare requires a legible order for services provided/ordered. Effective 1/1/2004, the method used (e.g. hand written, electronic, or signature stamp) to sign an order or other medical record documentation for medical review purposes in determining coverage is not a relevant factor. However, an indication of a signature in some form needs to be present. A claim will not be denied on the sole basis of type of signature submitted. A MD signature, of some type, is required for orders, therapy plans of treatment, and Certification of Medical Necessity. Additionally, it is requested that the physician orders/prescriptions not only be signed but dated.

Should you have any questions, contact your provider representative at 1-866-488-0545 or Janice Austin, Utilization Review Specialist at 410 561-4158 or Janice.austin@carefirst.com .

THIS BULLETIN SHOULD BE SHARED WITH ALL HEALTH CARE PRACTITIONERS AND MANAGERIAL MEMBERS OF THE PROVIDER/SUPPLIER STAFF. BULLETINS ISSUED AFTER OCTOBER 1, 1999 ARE AVAILBABLE AT NO-COST FROM OUR WEBSITE AT www.marylandmedicare.com