St Anthony's™

MEDICAL REVIEW PRIMER

What Is a Medical Review?

Most physician offices do not realize that quite a few of their claims undergo a medical review. Many offices think that a medical review is only when the payer asks to see specific information from the medical record so that this can be compared to the claim. However, this is not the case. Most of the claims that you submit for payment have been under some type of a medical review. In addition, it is important to remember that just because a claim has been paid, this does not mean that the third-party payer will not review the claim later.

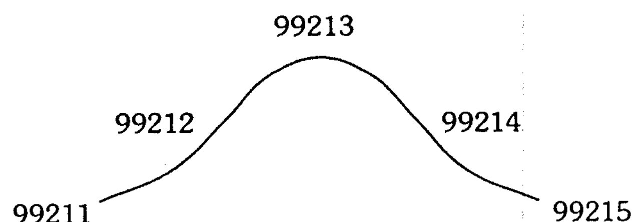
A medical review is the analysis of claims data performed by the third-party payer to determine areas of overutilization. Overutilization can be defined as the provision of services that are not considered "reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." The following information regarding medical review has been gleaned from the *Medicare Carriers Manual*. It should be noted, however, that many other non-Medicare payers use the same types of guidelines to conduct their own medical reviews.

If, during a medical review, it is determined by the payer that the potential for fraud and abuse exists, the carrier coordinates an investigation with the Medicare fraud unit. In addition, most carriers coordinate both pre- and postpayment reviews of data analysis to decrease the duplication of work.

What Triggers a Review

Medicare and other third-party payers routinely perform a medical review of claims. In addition to this routine review, certain providers are reviewed because the data elements on file are not what is expected when compared to other physicians of the same or similar specialty.

For example, most payers expect to see a bell-shaped curve when the evaluation and management codes are graphed.



In other words, usage of a level 1 established patient visit (CPT code 99211) is expected to be lower than a level 3 (99213) but approximately the same as a level 5 (99215) code. If, after data analysis, it appears as if your practice is utilizing only the highest level of service codes (99214 and above), this may trigger a medical review of your practice.

Complaints can also trigger a medical review. These complaints most often come from patients but can also come from other health care providers and third-party payers. For example, it is common for a medical review to be initiated by a Medicaid or Blue Shield payer if a Medicare medical review has revealed coding errors or fraud and abuse. Again, if it is determined during the medical review process that there is the possibility of fraud, the case will be referred to the payer's fraud unit for further investigation.

Medical Review Policy Development

Payers utilize many types of resources when constructing medical review policies. Medicare carriers develop policies based on a composite of statutory provisions, regulations, nationally published Medicare coverage policies and local medical review policies. Non-Medicare payers often adopt or adapt these same policies.

The Health Care Financing Administration (HCFA) has informed local carriers that they are to develop local medical review policies (LMRPs) in the absence of statutes, regulations or national coverage policies. These LMRPs may also be used to serve as an adjunct to, or further clarification of, national policies. However, it should be noted that the national policies

are the basis for which medical review decisions must be made.

Statutory Exclusions
The statutory authority for the majority of medical review policies can be found in section 1862 (a) (1) (A) of the Social Security Act, which excludes coverage for "items or services that are not reasonable and necessary for the diagnosis of illness or injury or to improve the functioning of a malformed body member."

Additional statutory exceptions to the exclusion list can be found in section 1862 (a) for items such as screening mammography, screening pap smears, pneumococcal, influenza and hepatitis B vaccines. These services have specific coverage guidelines that, once met, ensure coverage will be provided.

National Coverage Policies
A national coverage policy is the statement of the national policy regarding Medicare coverage and is:
—published in the HCFA regulations
—contained in a HCFA ruling, or
—issued as a program instruction, such as in the *Medicare Carriers Manual* or the *Coverage Issues Manual*.

National coverage policies indicate if and under what circumstances a service or item is covered. Carriers are instructed to apply all pertinent statutory provisions, regulations and national coverage policies when adjudicating claims.

When the national coverage policy indicates that a service or item is covered only under specific circumstances, the payer will reimburse for that service/item only when those circumstances are met. It is therefore very important that the claim submitted indicates the circumstance clearly by utilizing the appropriate ICD-9-CM, CPT or HCPCS Level II codes. The medical record documentation should support the use of those codes.

For example, the *Coverage Issues Manual,* section 65-8, states that, before payment is made for the implantation of an electrical nerve stimulator, all of the following conditions must be present:

- The implantation is used as a last resort for patients with chronic, intractable pain.
- Other treatment modalities have been tried and did not prove satisfactory or are contraindicated for the patient.
- The patient underwent psychological and physical screening evaluation and diagnosis by a multidisciplinary team before implantation.
- All facilities, equipment and professional and support personnel required for the proper diagnosis, treatment, training and follow-up care of the patient must be available.
- Demonstration of pain relief with a temporary, implanted electrode preceded permanent implantation.

The authority and responsibility to interpret the national coverage policies and apply them to individual claims is the carrier's. However, when making individual determinations, the carrier has no discretion and cannot deviate from the national policies.

Many policies approve coverage for certain types of therapies only when less aggressive, less costly therapies have been tried and failed. When providing these types of services, it is important that the payer be contacted to determine what the criteria are and if all of them have been met.

When a new national policy is developed, the carrier must notify the medical community of the policy and its effective date. This is usually done through the bulletins published by the Medicare carrier and by the third-party payer newsletters for non-Medicare payers.

In addition, it should be noted that while a national policy may state that a condition is covered for only diagnoses/conditions A, B and C, this does not give the carrier the basis to cover that service for *only* those conditions. When a national policy does not exclude coverage for a certain condition, individual consideration must be given unless there is a local medical review policy that automatically denies coverage for that specific reason.

Local Medical Review Policy
As stated above, individual Medicare carriers also have the authority to develop local medical review policies. When needed and in the absence of a national coverage policy for a particular service or item, the carrier may develop a LMRP to indicate whether the service or item is covered and under what clinical circumstances it is considered to be reasonable, necessary and appropriate.

HCFA has a standardized process for the development of LMRPs, which includes the development of draft policies based on review of medical literature and the carrier's understanding of local practice. Comments must be solicited from the medical community, including the Carrier Advisory Committee (CAC). These comments must be responded to and incorporated into the final policy. Providers must then be notified of the policy and its effective date. This most often occurs via the carrier bulletins your office receives.

An LMRP must be clear, concise and not restrict or conflict with the national policy. For example, if a national policy states that a given item is "covered for diagnoses/conditions A, B and C" the carrier may not develop a policy that states the service is covered only for diagnoses/conditions A and B.

Types of Medical Reviews
Basically, there are two types of medical reviews that are performed most often: the pre- and postpayment medical reviews. In addition to these types of reviews, there are also the focused medical review and the comprehensive medical review, which are usually performed when an aberration is noted. When performing these medical reviews, the payer usually identifies where services billed have had significant potential to be medically unnecessary, excessive or otherwise noncovered. Claims data are usually the source of identifying these areas. These claims data are compared to:

—national claim data
—payer claim data
—Office of the Inspector General information
—Medicare fraud unit information
—beneficiary and provider complaints
—referrals from peer review organizations, intermediaries or other federal programs
—referrals from licensing boards
—referrals from carrier advisory committees.

Prepayment Medical Reviews
A prepayment medical review is the process in which claims are subjected to auto-adjudicated (computerized) or manual medical reviews using national coverage policy and local medical review policies. Some examples of the auto-adjudicated systems are the Outpatient Code Editor and the Phase IV unbundling list. Local medical review information is usually published in the individual carrier bulletins.

Development of prepayment screens are based on national coverage policy or local medical review policy. These policies may suspend targeted claims for manual application of medical policy or may cause a claim to be denied outright.

The methodology used to focus these screens and target claims is developed to minimize the inefficient review and provider hassle. Medical review screens must be able to key in on a beneficiary's health insurance claim number, a provider's identification number (the PIN and UPIN numbers) and/or specialty, date of service(s), and the CPT, ICD-9-CM and HCPCS Level II and Level III codes. These screens perform several comparisons to deny or select cases for further medical review. These comparisons include:

1. Procedure to Procedure: This relationship permits the carrier to screen multiple services, both at the claim level and in history. For example, these screens can determine if the CPT codes indicated unbundled services, or if the patient has had the service previously and, therefore, the procedure could not be repeated (such as an appendectomy).

2. Procedure to Provider: For a given provider, this permits selective screening of services that need review. For example, how many cesarean sections are being performed by obstetricians.

3. Frequency to Time: This allows the payer to determine if the number of services indicated on the claim can actually be provided during the given time period. For example, if a patient is in the hospital for four days, but six hospital visits are indicated on the claim, this claim would be flagged for review.

4. Diagnosis to Procedure: This type of screen permits the payer to review the claim to determine the medical necessity of the services indicated. For example, a vitamin B^{12} injection is only considered medically necessary for the diagnosis of pernicious anemia, the absence of the stomach or a distal duodenum. If the diagnosis indicated on the claim is not one of the conditions listed above, the claim will be denied.

5. Procedure to Specialty: This allows the payer to determine if the services performed may be covered when provided by that specialty provider. For example, a claim for an EKG may be suspended for further review when submitted by a physician whose specialty is podiatry.

6. Procedure to Place of Service: A comparison of this type selectivly screens claims where the service was provided in a certain setting. For example, a level two new patient office or other outpatient visit (CPT code 99202) must have the place of service code 11 (office) or 22 (outpatient) indicated on the claim, or the claim will be denied.

HCFA has developed three categories of medical review screens.

Category One: These types of medical review edits are based solely on the evaluation of the information present on the claim. Usually, these edits compare two or more of the data elements listed above, such as the diagnosis to procedure code and/or procedure to place of service.

Category Two: This level of review may require information that is not on the claim to be reviewed, in ad-

dition to and compared with the information presented on the claim. For example, a selected procedure code may be compared to the history file of the beneficiary to determine how often that service has been rendered in the past. This type of claim review also can be triggered by submitting a claim incorrectly or incompletely. If your office receives a "Request for additional information" notice from the payer, at least this type of medical review is being performed on the claim.

Category Three: A category three medical review is performed for services from specific providers flagged for medical review. These providers are singled out due to unusual practice patterns, knowledge of service area abuses and/or utilization complaints received from beneficiaries or others. Category three reviews can be for all claims from a specific provider or for only certain services rendered by that provider. For example, all claims for holter monitoring from a specific provider could be reviewed because of known past abuses of this service.

Manual prepayment reviews are conducted by specially trained personnel, including registered nurses and physicians. There are three levels of manual reviews, including cliniciam reviews..

Level One:
First-level reviewers can only deny claims when there are detailed, written internal medical review guidelines. Claims that the reviewer is not trained to process or for which there are no written internal guidelines are referred for level two reviews or clinical reviews.

Level Two:
Level two reviews are also guided by internal medical review policies; however, these reviewers have a more highly trained skill level and are better able to interpret medical terminology.

Clinician Reviews:
Experienced RN reviewers generally need less detailed instructions from the payer and may also include the carrier's medical director. Both the nurses and the carrier medical director may call upon the clinical expertise of expert consultants for advice. Any determination by a clinician must be documented and include the rationale for the decision. The clinicians must also follow national coverage guidelines as well as local medical review policies; however, they may interpret "gray" areas not covered by these policies and, when necessary, evaluate the appropriateness of the service provided.

Postpayment Reviews:
Postpayment reviews identify claims that have been paid but may represent medically unnecessary care. When paid claims undergo a postpayment medical review and the payer discovers services that should not have been paid, corrective actions such as requesting a refund from the provider are instituted. During postpayment reviews, the payer also identifies areas where prepayment screens and/or edits should be improved or instituted.

Postpayment reviews are also commonly conducted when a provider has been notified of an incorrect billing practice and educated with the appropriate procedures. Providers may be referred to the fraud unit with recommendations for administrative sanctions and fines (including civil and criminal prosecution) when it is determined that the providers have failed to correct their inappropriate practices.

Focused Medical Reviews:
In addition to the above types of medical reviews, carriers will focus reviews on one area that has represented a significant area of overutilization. This approach is known as the Focused Medical Review.

Comprehensive Medical Reviews:
This type of review is a thorough analysis of a sample of processed claims and all the pertinent data, such as medical records and patient payment history, for a selected provider during a specified time period. A limited sample is usually taken. This limited sample usually consists of 15 patients randomly selected from the provider's database. Using these 15 patients, random dates of service are selected. These dates of service usually encompass a six-month period of time. The medical records associated with these claims are requested from the provider. The medical record documentation is compared to the claims to determine if the records substantiate the items/services billed. If so, the case is closed and the provider is notified. If not, the carrier calculates and recovers any overpayments.

Comprehensive medical reviews are usually performed on a provider who is suspected of providing noncovered or medically unnecessary services. It also serves as the basis for which overpayment assessments are computed. When a provider is selected by a Medicare carrier for a comprehensive medical review, corrective actions must be initiated within 12 months of selection. Case selection is based upon:

- Aberrations identified through the data analyses of paid claims
- Standard postpayment claims data reports
- Alerts received from other payers, the intermediary, peer review organizations and state Medicaid agencies

- Providers identified by
  - —the fraud unit
  - —the medical review staff
  - —beneficiaries
  - —review staff
  - —claims processing staff
  - —provider/professional relations staff
  - —private business staff
  - —newspaper accounts of provider's billing practices
  - —questionable newspaper or television advertising, and
  - —other sources.

Comparative Performance Report Requirements:
As mentioned earlier in this primer, a medical review is often triggered by a physician seeming to overutilize services when compared to his or her peers. Physicians and their office staff often ask, "How can I know how I compare with my peers?"

Medicare payers are required by law to analyze physician billing practices and to provide feedback to physicians on selected procedure codes compared with others in their peer group. The purpose in sending this information is to give the physician an opportunity to assess the appropriateness of his or her coding, billing and utilization practices relative to those of his or her peers. This report is called the Comparative Performance Report or CPR.

The Carrier Advisory Committee is presented by the carrier, either through a CAC meeting or by mail, with information on the educational nature of the CPRs, the physician selection process, how to interpret the report and how physicians may contact the committee members.

Each physician is selected to receive a CPR report through the mail. The report consists of a cover letter and subsequent page(s) that address individual or multiple codes. At a minimum, the information addressing the codes must include:
- —the specialty
- —the procedure code
- —the physician frequency of the billing code for every 100 patients, and
- —the peer group frequency of the billing code for every 100 patients.

A CPR will not be sent to a physician who is currently under corrective action or to a physician with a high utilization of a service because he or she is the sole provider of that service in a geographical area. Also excluded from receiving a report are physicians who are under investigation by the fraud and abuse unit or by the Office of the Inspector General.

Payer Actions
Payers have a variety of actions that can be taken when they find a claim error. During a prepayment review, the most common action is the denial of that particular service or procedure. In some cases, the procedure code for which the flag was raised may be changed to another code that the payer feels is more appropriate. However, if a payer has changed a code, verify that this was correct. In some cases, it may be that the diagnoses codes report was incorrect and did not substantiate the medical necessity for the service provided. In those cases, resubmit the claim following the payer's instructions and with the corrected information.

Other actions that may be taken include:

- **Educating providers**: This may be performed individually when it is found that an individual provider is unaware of policies regarding procedures performed on a regular basis. When new policies are developed or when multiple providers need to be educated regarding a policy, group educational sessions, such as seminars, may be conducted by the payer. Whenever a payer is offering an educational session regarding policies and procedures, it is advisable that a member of the staff attend.

- **Identify the provider to the fraud unit**: If the medical review personnel feel that the physician was committing fraud intentionally, the provider information will be forwarded to the fraud unit for further investigation.

- **Comprehensive Medical Review**: If the pre- or postpayment medical review indicates a large number of questionable claims, the payer's medical review staff may elect to refer the provider for a comprehensive medical review.

- **Overpayment assessments**: There are three types of overpayment assessments that can be made:

  - *Actual Overpayment*—The sum of payments made to a provider for the items/services that were determined to be medically unnecessary or incorrectly billed during readjudication.

  - *Projected Overpayment*—The numeric overpayment obtained by projecting an overpayment for all similar claims in the universe under review.

  - *Limited Projected Overpayment*—The numeric overpayment obtained by projecting an overpayment for all similar claims in the uni-

verse under review from a limited sample (such as a six-month period).

Tools to Help You Pass a Medical Review

The following tools can help your office pass a medical review with flying colors. These tools should be reviewed by all staff and kept in a convenient location so that they may be referred to frequently.

Carrier Bulletins:

Carrier bulletins should be read immediately upon receipt by all members of the staff, particularly the physician. Consider using a routing slip to be certain all members of the staff have read them. Carrier bulletins contain information regarding new coverage policies that will affect medical reviews. In addition, when performing a new test or service, review the carrier bulletins you have received to determine if a policy exists. Keep bulletins in one binder in a convenient location for all staff members.

Documentation Guidelines:

Documentation supports the codes you have assigned to a claim. All staff members, including the physician, should become familiar with the official HCFA documentation guidelines. In addition, many carriers develop documentation guidelines that are specific to certain procedures or services and publish these guidelines in their bulletins. If you notice publication of a documentation guideline for a specific procedure or service performed in your office, follow these guidelines. Many offices use these guidelines to develop a documentation sheet for that particular service to ensure correct documentation.

Third-Party Payer Provider Manuals:

Provider manuals are the individual payer's "Holy Grail." Be certain to obtain a provider manual and ***Read It***! Provider manuals often define that payer's medical review policies and procedures, letting you know what they are looking for on a claim. If your office has an old, outdated provider manual, request a new one and keep it updated as changes are published.

HCFA's Unbundling List:

Other payers, not only Medicare, follow this unbundling list, so you should, too. If you consistently unbundle claims, that is, charge for individual procedures when they are considered an integral part of the major procedure being performed, the payer may investigate your practice for fraud and abuse.

Clinical Articles Regarding the Medical Necessity of Procedures:

If your practice is considering doing a procedure for a condition that the procedure is not usually performed for, or if your practice will be performing a relatively new procedure (which is not considered experimental), you should keep the medical literature regarding that procedure handy. If the payer denies the procedure, or if additional information is requested, send copies of this information along with a cover letter explaining the procedure and justifying the medical necessity.

Payer Correspondence:

Keep payer correspondence such as letters together in an organized manner either by date or by topic so that they can be referred to easily. When correspondence addresses medical necessity or coverage issues, be certain that all staff members familiarize themselves with these issues.

Current ICD-9-CM, CPT and HCPCS Level II Code Books:

Coding reflects the reason for the visit and what was done during the encounter. By using old, outdated codes, you are not communicating these issues to the payer.

Closely Review the Explanation of Benefits (EOB):

It is important that the provider reconcile the EOB with the services rendered. Examine the EOB and determine if any services were denied. Services may have been denied because coverage is not provided or for other reasons, such as lack of medical necessity. In some cases, such as medical necessity denials, the claims may be resubmitted for processing with additional information. This information can be the documentation that the provider has regarding the encounter, or a cover letter.

Determine Specialty Designation:

All payers group physicians by their specialties and expect to see certain services performed only in that specialty. Also, it is expected that a particular specialty's utilization of certain services will be much higher than that of other specialties. For example, payers expect to see a gynecologist's utilization of code 58120, Dilation and curettage, to be higher than that of other specialists, such as a general surgeon. If your payer has incorrectly designated your specialty, this may flag your claims for increased review.

Perform Your Own Medical Reviews:

Another helpful tool is to perform medical reviews on yourself. Determine the criteria that your payers use and randomly select 10–15 medical records. Perform a medical review on these records using the payer's guidelines. Educate the physician and office staff with your findings. This should be done on a monthly basis and then, perhaps, on a once-per-quarter basis.

Self Reviews

Performing in-house medical reviews can accomplish several things. First, by performing self reviews, you

fix problem areas before they go to the payer, preventing costly payer reviews. Second, medical self reviews help to ensure that when your claims are reviewed, there is less chance of denial and/or overpayment or refund requests. Third, and last but not least, medical self reviews can decrease claim-processing time and downcoded claims, thereby increasing payments and stabilizing cash flow.

Many offices do not perform in-house medical reviews because they assume that the procedure is lengthy and complicated. However, once the necessary tools described below are gathered, medical reviews can become part of the normal operating process of the office.

Determine the payer hit list:
When performing self reviews, select an item and hone in on it. When initially setting up in-house medical reviews, compile a list of the things that you know your payer is performing medical reviews of when it does a review. Make sure that this list contains only those services commonly provided in your practice.

The best place in which to discover what the payer is performing reviews on is the payer's bulletins. These bulletins commonly list newly written local medical review policies. These policies are developed because the payer has discovered problems in these areas. Another resource is your explanation of benefits. If you see claims that are denied because of a lack of medical necessity or codes that are changed by the payer before payment processing, these need to be added to your top 10 hit list.

For example, if you know that your payer indicates that fungal cultures performed at the same encounter as nail debridement will be denied because of the lack of medical necessity, and your office performs a significant number of these procedures, select that as a medical review for your office to perform.

Select the type of review:
Once the "top 10 hits" of the payer have been determined, select only one of the items for review at a time. This will ease the burden that staff will be under and allow your staff to perform a detailed review and not a "rush job." Do not choose services or conditions in which codes have been recently changed, as this will cause confusion with the office staff. Hold off on these areas for approximately four to six months.

Gather the payer guidelines:
After deciding what your review will focus on, gather all the necessary information available regarding that topic. Read past bulletins for policies, determine if the provider manual has any information regarding the subject and gather clinical resources and payer correspondence. If you are reviewing ICD-9-CM, CPT or HCPCS Level II or Level III codes, determine the most appropriate code to indicate that service.

Develop a medical review report card:
Once the information is gathered, write a medical review checklist to use. This checklist can be thought of as the report card of the review. For example, an item on a review of B^{12} injections could be:

Did the diagnosis indicate:
- pernicious anemia ________?
- absence of the stomach ________?
- absence of the distal duodenum ________?

Using this type of form allows more than one staff member to perform the review; however, there is still consistency in the information being utilized to review the claim.

Select the medical records:
Now that the type of review has been selected and the report card has been developed, select the medical records for which the review will be performed. Select only those medical records that have the service or other item being reviewed. Pull a copy of the claim for the service that is being reviewed.

Also, only pull the number of charts that can comfortably be reviewed by the staff within a timely period. If only 10 records can be comfortably reviewed, pull only 10 records. Remember, it's better to review a limited number or records accurately than a large number of records haphazardly. In addition, if you make the review process too cumbersome, staff are likely to resist performing reviews on a regular basis.

Perform the review:
Once the records have been pulled, review each record and its claim form using the report card to determine the information that needs to be examined. Ascertain whether or not that claim "passed" the review process.

Determine areas needing improvement:
For all those claims that failed the review, determine what area(s) need to be improved. Find out where the failures were due to coding areas, lack of understanding of the medical policies regarding those services and/or incomplete or incorrectly completed claim forms. These areas will be where you focus your improvement efforts.

Develop improvements:
Take the list of failed subjects and develop "cheat sheets" that can be used in office billing policies and procedures, or gather additional information from the payers to prevent these errors from recurring.

Implement staff education:
Perform staff education (including the physician) regarding what needs to be done to prevent claim delays or denials. If tools such as "cheat sheets" are developed, train staff on the proper method to use these tools. Explain the need for these tools and ask if anyone has any suggestions that would make the process smoother or less burdensome. By involving staff, you are less likely to face resistance and more likely to achieve compliance.

Medical Review Flowchart: