Why Medical Review?

Sections 1833(e), 1842(a)(2)(B) and 1862(a)(1) of the Social Security Act state the Centers for Medicare & Medicaid Services (CMS) is required to protect the Medicare program against inappropriate payments that pose the greatest risk to the program and take corrective actions against the risks. To meet this requirement, CMS contracts Medicare Administrative Contractors (MACs) to perform analysis of claims data to identify atypical billing patterns and perform claims review.

What Is Medical Review?

Medical review is the collection of information and review of medical records by MACs to ensure that payment is made only for services that meet all Medicare coverage, coding, and medical necessity requirements. Medical review activities are directed toward areas where data analysis indicates questionable billing patterns. Validating initial findings of the medical review evaluation may require additional review resulting in corrective action.

According to CMS, the goal of the medical review 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 medical review program, the MACs:

- Proactively identify patterns of potential billing errors concerning coverage and coding made by providers through analysis of data (e.g., profiling of providers, services or beneficiary utilization) and evaluation of other information (e.g., complaints, enrollment and/or cost report data).
- Take action to prevent and/or address the identified error. Errors identified will represent a continuum of intent.
- Publish local medical review policy to provide guidance to the public and medical community about when items and services will be eligible for payment under the Medicare statute.


Program Integrity Manual (CMS Pub. 100-08) Chapter 3, Section 14 [www.cms.hhs.gov/manuals/downloads/pim83c03.pdf](http://www.cms.hhs.gov/manuals/downloads/pim83c03.pdf)
Compiling the ADR Packet

Putting the Packet Together

1. Print a screen shot of FISS page 07 and utilize it as the top page of your ADR packet or ADR notification letter.

2. Use a generic cover letter (See Sample ADR Response Cover Letter) stating the attached forms are in response to the ADR requested for:
   a. Provider number
   b. Patient’s name
   c. Patient’s HICN (Health Insurance Claim Number)
   d. Dates of service requested for review

   Note: Reviewers base their decision on the contents of the medical records included in the ADR packet and often do not read a letter describing the patient’s condition. As you read further, you will learn the process that will replace that letter. The notification letter or copy or the DDE screen is always the first form in the packet after the cover letter.

3. Include documents listed on the MAC’s “Required List” on the notification letter or the Direct Data Entry (DDE) screen

4. **Do include:**
   a. All documents listed on the “Required List” on the notification letter or the DDE ADR computer screen

5. **Do not include:**
   a. Documents not listed on the “Required List” unless they provide supportive evidence

6. Describe each form or set of forms by placing a cover sheet (See Examples of ADR Packet Cover Sheets) with a form description written in large font on top such as:
   a. REFERRAL INFORMATION
   b. OASIS DOCUMENTS
   c. MEDICATION PROFILE
   d. PLAN(S) OF CARE
What to do if Targeted Medical Review Appears Imminent

During your probe edit, it will become apparent that TMR is imminent based on:

- The number of denials incurred
- The dollar amount of denials
- The length of time your agency remains on review

Once your agency determines the probability of TMR is high, your agency should seriously consider the following:

- Inform staff of the possibility of being placed on TMR. Solicit and evaluate their recommendations for improvement
- Assess the need for additional education
- Consider requesting an educational call presented by the MAC
- If not already implemented, consider initiation of clinical review of every visit note to assure documentation supports a home health criteria

Another, and probably the most important consideration, is the development and implementation of an internal Corrective Action Plan (CAP), a formal written plan outlining the corrective actions that have been or will be put into place. Once your agency has identified the problem areas during the ADR process, an internal CAP should be developed immediately.

The CAP should include:

- A timeline with start and completion dates
- Periodic evaluation dates
- A list of staff involved and how that staff contributes to the plan (may use titles)
- Goals for the CAP and measurements of success
- Alternative goals if original goals are not met
- Remediation measures if goals are not met
- Specific, concrete interventions to address problem areas identified.

Once implemented, monitor the CAP on a regular basis for effectiveness.