

Chapter 12: Medical Review

Introduction

NHIC, Corp. DME MAC Jurisdiction A currently performs the following Medical Review (MR) functions:

- Performance of MR not for BI functions as outlined in *MLN Matters* article 5765 and Chapter 5 of Pub. 100-8, *Medicare Program Integrity Manual (PIM)*
- Comprehensive Error Rate Testing (CERT)
- Local Coverage Determinations (LCDs)
- Advance Determination of Medicare Coverage (ADMC)
- Healthcare Common Procedure Coding System (HCPCS)
- Medical Review not for BI Claim Edits
- Probe Reviews
- Supplier Education
- Medical Review of Claims (not for BI purposes)

TriCenturion, a Program Safeguard Contractor (PSC), continues to perform the BI functions for DME MAC A.

Information relating to MR topics is available on the DME MAC A Web site at : http://www.medicarenhic.com/dme/medical_review/mr_index.shtml

For any information relative to BI (Fraud and Abuse), suppliers must continue to access the TriCenturion Web site at: <http://www.tricenturion.com>

General Program Overview

What is Medical Review?

Medical Review (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 Medical Review 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 Medical Review 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.

For more information regarding the Medicare Medical Review Program, visit the CMS web site at: <http://www.cms.hhs.gov/MLNProducts/downloads/MedReviewProgbroch07.pdf>

Healthcare Common Procedure Coding System

The Healthcare Common Procedure Coding System (HCPCS) was developed in 1983 for the purpose of standardizing the coding systems used to process Medicare claims, and it has been selected as the approved coding set for entities covered under the Health Insurance Portability and Accountability Act (HIPAA). The HCPCS coding system is used to bill for supplies, materials, and certain services and procedures, which are not defined in the Current Procedural Terminology, Fourth Edition (CPT-4). HCPCS codes must be used when billing Medicare carriers, including DME MAC A, whether on the CMS-1500 claim form or when submitting electronic claims, via the Common Electronic Data Interchange (CEDI).

There are two levels of codes within the HCPCS coding system:

- Level I CPT Codes
- Level II National Codes

Level I codes are identical to those listed in the CPT published by the American Medical Association (AMA). Most of the procedures and services performed, even for Medicare patients, are billed using CPT codes. **Note:** These codes are not used for items or services that are billed to DME MAC A.

Level II codes are alpha-numeric codes, which start with a letter followed by four numbers. The range of Level II codes is from A0000 through V5999. HCPCS National Level II codes are uniform in description throughout the United States, and CMS monitors the system to ensure uniformity. The main body of Level II codes is divided into eighteen sections, with the supplies, materials, injections, and services presented in alpha-numeric order within each section.

The eighteen sections of HCPCS National Levels are:

Code Range	Section
A0000 - A0999	Transportation Services
A2000 - A2999	Chiropractic Services
A4000 - A4999	Medical and Surgical Supplies
A9000 - A9999	Miscellaneous and Experimental
B4000 - B9999	Enteral and Parenteral Therapy
D0000 - D9999	Dental Procedures
E0000 - E9999	Durable Medical Equipment (DME)
H5000 - H5999	Rehabilitative Services
J0000 - J8999	Drugs Administered Other than Oral Method
J9000 - J9999	Chemotherapy Drugs
K0000 - K9999	Temporary Codes
L0000 - L4999	Orthotic Procedures
L5000 - L9999	Prosthetic Procedures
M0000 - M9999	Medical Services
P0000 - P9999	Pathology and Laboratory
Q0000 - Q9999	Temporary Codes
R0000 - R5999	Diagnostic Radiology Services
V0000 - V2999	Vision Services
V5000 - V5999	Hearing Services

Note: Temporary Codes cover two code ranges.

In addition to codes for specific services or procedures, there are codes that do not specifically describe a service or procedure. These codes are defined as “not otherwise classified” or “not otherwise specified” codes, which at times are referred to as miscellaneous codes. Providers have to properly identify the services or procedures being supplied, and documentation must be made available upon request.

There are also HCPCS National Level II modifiers. A modifier allows the healthcare professional to indicate that the service or procedure performed was altered by a specific circumstance but not changed in its definition or code. The modifying circumstance is identified by adding a two-position modifier to the basic procedure code.

Effective January 1, 2005, Medicare providers no longer have a 90-day grace period to use discontinued HCPCS codes for services rendered in the first 90 days of the year. In addition, CMS will no longer allow a 90-day grace period for discontinued codes resulting from any mid-year HCPCS updates. Use of such codes to bill services provided after the date on which the codes are discontinued will cause claims to be returned and not paid, since the HIPAA transaction and Code Set Rule requires providers to use the medical code set that is valid at the time that the service is provided.

HCPCS code/modifier recognition does not imply that a service is covered by Medicare, or, where it is, does not imply that the payment level will be different from other services of a similar nature. Refer to the individual medical policies for specific coding provisions.

The *HCPCS Jurisdiction List* designates whether a code should be billed to DME MAC A or to the Local Carrier (Medicare Part B contractor). Items that do not meet the requirements under a benefit category within the DME MAC A jurisdiction will be denied as non-covered when submitted for payment. For more information on HCPCS codes and modifiers, refer to the Medical Review section of the DME MAC A Web site at:

http://www.medicarenhic.com/dme/medical_review/mr_index.shtml

Effective August 18, 2008 - SADMERC Transition to PDAC

Noridian Administrative Services, LLC (NAS) has been named the Pricing, Data Analysis and Coding (PDAC) Contractor by the Centers for Medicare & Medicaid Services. NAS currently performs the following activities that Palmetto GBA, as the Statistical Analysis DME Regional Carrier (SADMERC), previously performed:

- Provide data analysis support to the DME Program Safeguard Contractors (PSCs)
- Guide manufacturers and suppliers on the proper use of the Healthcare Common Procedure Coding System (HCPCS) through product reviews and decisions
- Conduct national pricing functions for DMEPOS services

- Assist CMS with DMEPOS fee schedules

Visit the PDAC Web site at <http://www.dmepdac.com> to obtain additional HCPCS information.

Local Coverage Determinations

Local coverage determinations (LCDs) specify under what clinical circumstances a service is covered, including under what clinical circumstances it is considered to be reasonable and necessary, and correctly coded. An LCD is an administrative and educational tool to assist providers in submitting correct claims for payment. LCDs outline how contractors will review claims to ensure they meet Medicare coverage and coding requirements.

Contractors may review claims on either a prepayment or post-payment basis, regardless of whether an LCD exists for that item or service. When making individual claim determinations, the DME MAC shall determine whether the item or service in question is covered and/or correctly coded.

An item or service may be covered by Medicare if it meets all of the following conditions:

- It is one of the benefit categories described in Title XVIII of the Social Security Act (the Act)
- It is not excluded by Title XVIII of the Act, other than Section 1862(a)(1)
- It is reasonable and necessary under Section 1862(a)(1) of the Act

Contractors publish (i.e., post to their Web site) LCDs to provide guidance to the public and medical community within a specified geographic area. The current (final) LCDs for jurisdiction A are available in the Medical Review section of the DME MAC A Web site at: http://www.medicarenhic.com/dme/medical_review/mr_lcd_current.shtml. For more information on LCDs, suppliers should refer to Chapter 13 of Pub. 100-8, *Medicare Program Integrity Manual* (<http://www.cms.hhs.gov/manuals/downloads/pim83c13.pdf>).

Contractors shall develop new LCDs when they have identified an item or service that is never covered under certain circumstances and wish to establish automated review in the absence of a National Coverage Determination (NCD) or coverage provision in an interpretive manual that supports automated review. To ensure that all LCDs remain accurate and up-to-date at all times, at least annually, contractors must review and appropriately revise LCDs based upon CMS' NCDs, coverage provisions in interpretive manuals, national payment policies, and national coding policies. Additional coverage information is found in Pub. 100-3, *Medicare National Coverage Determinations Manual*, and in Pub. 100-2, *Medicare Benefit Policy Manual*, both manuals can be found on the CMS Web site at: <http://www.cms.hhs.gov/Manuals/IOM/list.asp>, or via the Medicare Coverage Home page at: <http://www.cms.hhs.gov/CoverageGenInfo/>

If an LCD has been rendered useless by a superseding national policy, it must be retired. Jurisdiction A LCDs will be added/archived to the appropriate section of the DME MAC A Web site as they are finalized/retired. Suppliers should visit the DME MAC A Web site on a periodic basis to remain current with the latest information regarding LCDs for DME MAC Jurisdiction A.

Comprehensive Error Rate Testing

CMS developed the Comprehensive Error Rate Testing (CERT) program to produce national, contractor-specific, and service-specific paid claim error rates. The program has independent reviewers that periodically review representative random samples of Medicare claims that are identified as soon as they are accepted into the claims processing system at Medicare contractors. The independent reviewers medically review claims that are paid and claims that are denied to ensure that the decision was appropriate. As such, suppliers should be aware that one or more of their claims may be selected in the CERT sampling process. When this occurs, the supplier will receive a letter from the CERT contractor requesting medical documentation for the selected claims.

DME MAC A is responsible for reviewing, responding to, and returning monthly notification reports to CERT for Jurisdiction A.

It is important for suppliers to respond to the CERT contractor's requests for medical records and to answer/direct questions to the proper representative. Failure to do so could subject the claim(s) in question to an overpayment or possible referral to the OIG.

Note: Submitting documentation to the CERT contractor is not in violation of the HIPAA Privacy Rules.

For more information about CERT, please visit the DME MAC A Web site at:

http://www.medicarenhic.com/dme/dmerc_cert.shtml

Suppliers should also refer to Chapter 12 of Pub. 100-8, *Medicare Program Integrity Manual*

<http://www.cms.hhs.gov/manuals/downloads/pim83c12.pdf>

Additionally, the booklet "*Medicare Claim Review Programs: MR, NCCI Edits, MUEs, CERT, and RAC*" explains the different CMS claim review programs and assists providers in reducing payment errors; in particular, coverage and coding errors. This brochure is available at: http://www.cms.hhs.gov/MLNProducts/downloads/MCRP_Booklet.pdf