Dynamic Chiropractic

BILLING / FEES / INSURANCE

Getting More From Medicare (Pt. 2)

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WHAT YOU NEED TO KNOW

- The reviewers are required to provide you with a minimum amount of time to respond to an ADR.
- The reviewers are also required to complete the review and send you the results within a specific amount of time.
- If you have questions about the results of the review, then contact the Medicare administrative contractor and ask them. They are required to provide you with additional information if you ask.

In the first part of this two part series [September issue], I reviewed who can request records, who can review them, what needs to be in the notice, and that Medicare cannot be overly burdensome with its requests. In this part, let's consider how much time the reviewer must allow you to respond to the ADR, what they have to consider during the review, how long they have to provide you with the results, and how much information about the review they are required to provide you.

How Much Time to Respond?

The reviewers are required to provide you with a minimum amount of time to respond to an ADR. According to the *Medicare Program Integrity Manual*, chapter 3, Section 3.2.3.3, the doctor has a prescribed minimum time limit to respond to the ADR:

The MACs, UPICs and RACs shall notify the third party and the billing provider or supplier that they have 30 calendar days to respond for a prepayment review or 45 calendar days for a postpayment review for MACs and RACs and 30 calendar days for UPICs. For prepayment review, the MACs and UPICs shall pend the claim for 45 calendar days. This 45 day time period may run concurrently as the 45 days that the billing provider or supplier has to respond to the ADR letter. The MACs and UPICs have the discretion to issue as many reminder notices as they deem

appropriate to the third party via email, letter or phone call prior to the 30th or 45th calendar day, as discussed above. Contractors shall include language in the denial notice reminding providers that beneficiaries cannot be held liable for these denials unless they received proper liability notification before services were rendered, as detailed in CMS Pub.100- 04, Medicare Claims Processing Manual, chapter 30.

What Will Be Considered

When Medicare sends you an ADR, it is generally focused on a single date of service. But we know from the chiropractic treatment paradigm that it is impossible to determine the medical necessity of care from reviewing the records of a single date of service.

When this happens, you need to send the requesting contractor the appropriate records necessary to determine the medical necessity of care. We know that includes the assessment/evaluation visits before and after the date of service in question, and all of the treatment visits between those assessment/evaluation visits. The Medicare reviewer will be required to review all of the records submitted based on clinical review judgment.

According to the *Medicare Program Integrity Manual*, chapter 3, Section 3.3.1.1(B), clinical review judgment involves two steps:

- *The synthesis of all submitted medical record information (e.g. progress notes, diagnostic findings, medications, nursing notes, etc.) to create a longitudinal clinical picture of the patient; and*
- *The application of this clinical picture to the review criteria is to make a reviewer determination on whether the clinical requirements in the relevant policy have been met. MAC, CERT, RAC, and UPIC clinical review staff shall use clinical review judgment when making medical record review determinations about a claim.*
- *Clinical review judgment does not replace poor or inadequate medical records.*
- *Clinical review judgment by definition is not a process that MACs, CERT, RACs and UPICs can use to override, supersede or disregard a policy requirement.*
- *Policies include laws, regulations, the CMS' rulings, manual instructions, MAC policy articles attached to an LCD or listed in the Medicare Coverage Database, national coverage decisions, and local coverage determinations.*

The failure of a reviewer to review all of the documentation provided could prove to be the basis of an appeal because the reviewer did not use clinical review judgment as required by Medicare regulations.

When You Can Expect Findings

The reviewers are required to complete the review and send you the results within a specific amount of time. *The Medicare Program Integrity Manual*, chapter 3, Section 3.3.1.1(H) states:

The MAC shall make a review determination, and mail the review results notification letter to the provider within 60 calendar days of receiving the requested documentation. For claims associated with any referrals to the UPIC for program integrity investigation, MACs shall stop counting the 60-day time period on the date the referral is made. The 60-day time period will be restarted on the date the MAC received requested input from the UPIC or is notified by the UPIC that the referral has been declined.

If you have not been notified within the 60-day period, check your remittance advisory to see if you have been paid for that claim. If you have not been paid or have not received a determination by

the 70-day mark, then contact the Medicare administrative contractor and ask about the status of the review.

How Much Information Can You Expect to Receive?

Medicare administrative contractors are required to make specific information available to you regarding the results of the review. According to the *Medicare Program Integrity Manual*, chapter 3, Section 3.6.4 (B):

The MACs need provide only high-level information to providers when informing them of a prepayment denial via a remittance advice. In other words, the shared system remittance advice messages are sufficient notices to the provider. However, for medical record review, the provider should be notified through the shared system, but the MAC shall retain more detailed information in an accessible location so that upon written or verbal request from the provider, the MAC can explain the specific reason the claim was denied as incorrectly coded or otherwise inappropriate.

If you have questions about the results of the review, then contact the Medicare administrative contractor and ask them. They are required to provide you with additional information if you ask.

It is rare that a reviewer will not follow these regulations. That being said, I have been involved in cases in which the reviewers have played fast and loose with the rules. They have done things like calling the office and demanding that records be faxed to them the same day.

If something like this should happen to you, then quote the regulations to them and talk to their supervisors. You do not need to take any abuse from a reviewer.

Take-Home Points

Medicare is entitled to access to patient records in order to determine if payment is appropriate. However, when asking for those records it has specific rules and regulations it is required to follow; and rules and regulations for reporting the results of these reviews.

I have given you an overview of these rules, along with the citations of where they can be found. If reviewers do not follow these rules and regulations then you have a basis for challenging them – and the tools necessary to do so.

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