Medicare's Rules for Records Requests

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The New ABN

- The new ABN was just released on April 4.
- By law, every three years the ABN needs to be updated and approved by the Office of Management and Budget.
- That means that something needs to change on the ABN for it to be approved.
- The change to the new ABN is the expiration date.
- The new ABN expires on 01/31/2026.
- Everything else is the same including the procedures for completing and using the ABN.
- You can start using it now but it is mandatory on 06/30/2023.

Introduction

- There are times when Medicare will need additional information in order to determine whether or not to pay for a claim.
- This request for information is referred to as an Additional Documentation Request or ADR.
- Each request must contain certain information and provide the doctor with a minimum amount of time to respond to the request.
- There are four entities within Medicare that can make an ADR.
- According to the Medicare Program Integrity Manual, Chapter3, Section 3.3.1.1(A):
- Medical record review involves requesting, receiving, and reviewing medical documentation associated with a claim.
- Medical record review, for the purpose of determining medical necessity, requires a licensed medical professional to use clinical review judgment to evaluate medical record documentation.

Who Can Request Records

- These are:
  - The Comprehensive Error Rate Testing contractor or CERT
  - The Medicare Administrative Contractor or MAC
  - The Recovery Audit Contractor or RAC
  - The Universal Program Integrity Contractor or UPIC
- These contractors vary in severity
- A request from a CERT contractor is pure luck of the draw and has little to no risk of consequences for the doctor.
- A request from a MAC is what you will most commonly experience and the risk is a denial of the claim and no payment.

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- RAC contractors are not currently focused on chiropractic.
- A request from a UPIC contractor should cause alarms to go off in your head.
- UPICs investigate fraud allegations and if they are requesting records then you have a problem.
- Get help as soon as possible.
- According to the Medicare Program Integrity Manual, Chapter3, Section 3.3.1.1(C):
- "The MACs, MRAC, and CERT shall ensure that medical record reviews for the purpose of making coverage determinations are performed by licensed nurses (RNs), therapists or physicians."
- "UPICs, RACs and the SMRC shall ensure that the credentials of their reviewers are consistent with the requirements in their respective SOWs."
- "During a medical record review, nurse and physician reviewers may call upon other health care professionals (e.g., dieticians or physician specialists) for advice."
- "The MACs, MRAC, and CERT, shall ensure that services reviewed by other licensed health care professionals are within their scope of practice and that their MR strategy supports the need for their specialized expertise in the adjudication of particular claim type (i.e., speech therapy claim, physical therapy)."

Who Can Review Your Records

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What is in the Request for Records

- According to the Medicare Program Integrity Manual, Chapter3, Section 3.2.3.4 the ADR must contain:
- Introductory Paragraph
    - CMS as the government agency making the request
    - The program making the request (e.g. the MAC program, the SMRC program, the Recovery Audit Program, the CERT program)
    - The regulations and/or laws that apply to the request
- The first paragraph in the ADR may identify the following:

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    - The program purpose;
    - Where additional information about the program and regulations can be found, for example, a website reference
    - Additional program information that may be helpful to the provider or supplier
- Reason for Selection
    - The reason the provider or supplier was sent the ADR letter and notes about the claims under review
- Action
    - The action(s) the provider or supplier shall take as a result of receiving the ADR letter
- When
    - The date a provider/supplier shall reply to the ADR letter and submit the documentation to the contractor
- Consequences
    - The consequences if the provider or supplier fails to submit the requested documentation
- Instructions
    - Instructions and notes that will help the provider or supplier respond to the ADR letter
- Submission Methods
    - The methods the provider or supplier can submit the requested documentation
- Questions
    - Contractor contact information for provider inquiries related to the ADR
- Attachments / Supplementary Information
    - If there are attachments or other supplementary information associated with the ADR, provide a listing of the attachment titles or provide the supplementary information
- Additionally the Medicare Program Integrity Manual, Chapter3, Section 3.2.3.4 has these general considerations:
- The MAC shall use discretion to ensure that the amount of medical documentation requested does not negatively impact the provider's ability to provide care
- The MACs, CERT, SMRCs, and Recovery Auditors, shall request records related to the claim(s) being reviewed and have the discretion to collect documentation related to the beneficiary's condition before and after a service
- The MACs, Recovery Auditors, and SMRCs have the discretion to issue as many reminder notices as they deem appropriate. Reminder notices can be issued via email, letter, or phone call
- The MACs, Recovery Auditors, and SMRCs shall not target their ADRs to providers based solely on the provider's electronic health record status or chosen method of submitting records

How Long do you Have to Submit the Documents

- 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:

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- 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

Clinical Review Judgment

- When Medicare sends you an ADR they generally are focused on a single date of service.
- We know from the Chiropractic Treatment Paradigm that it is impossible to determine the medical necessity of care from the review of 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.
- The Medicare Program Integrity Manual, Chapter 3, Section 3.3.1.1(B) states:
- "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.

Communicating the Results

- 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.
- 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."

Summary

- Medicare is entitled to access to patient records in order to determine is payment is appropriate.
- However, when asking for those records they have specific rules and regulations that they are required to follow.
- Also they have 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 you have the tools necessary.