
Program Memorandum Intermediaries/Carriers

Department of Health and
Human Services (DHHS)
HEALTH CARE FINANCING
ADMINISTRATION (HCFA)

Transmittal AB-00-72

Date: AUGUST 7, 2000

CHANGE REQUEST 1285

SUBJECT: Medical Review Progressive Corrective Action (PCA)–ACTION

A. GENERAL INFORMATION.--This instruction provides further guidance, underlying principles and approaches to be used in deciding how to deploy resources and tools for medical review. These concepts are already part of existing manual instructions (e.g., how to conduct medical review) but are amplified here for easy understanding of expectations and basic requirements. The attached chart (Exhibit 1) provides a graphic representation of some key steps that are important for efficient and effective use of medical review resources and tools. These include:

1. THE DECISION TO CONDUCT MEDICAL REVIEW SHOULD BE DATA-DRIVEN. Data analysis is an essential first step in determining whether patterns of claims submission and payment indicate potential problems. Such data analysis may include simple identification of aberrancies in billing patterns within a homogeneous group, or much more sophisticated detection of patterns within claims or groups of claims that might suggest improper billing or payment.

Data analysis itself may be undertaken as part of general surveillance and review of submitted claims, or may be conducted in response to information about specific problems stemming from complaints, provider or beneficiary input, fraud alerts, reports from HCFA, other contractors, or independent government and nongovernment agencies.

2. VALIDATE POTENTIAL PROBLEMS BY CONDUCTING "PROBE" REVIEWS. Before deploying significant medical review resources to examine claims identified as potential problems from data analysis, take the interim step of selecting a small "probe" sample of potential problem claims (prepayment or postpayment) to validate the hypothesis that such claims are being billed in error. This ensures that medical review activities are targeted at identified problem areas. Such a sample should be large enough to provide confidence in the result, but small enough to limit administrative burden. A general rule of thumb for the decision about how many claims should be included in the probe sample is that it should not exceed more than 20-40 claims for any individual provider (in the case of a hypothesized provider specific problem), or 100 claims distributed among a wider universe of providers (in the case of a hypothesized systematic problem). For provider specific problems, notify providers (in writing or by telephone) that a probe sample is being done and of the results of the probe review. Contractors may use a letter similar to the letter in Program Integrity Manual (PIM) Exhibit 7.5 when notifying providers of the probe review and requesting medical records.

3. SUBJECT PROVIDERS ONLY TO THE AMOUNT OF MEDICAL REVIEW NECESSARY TO ADDRESS THE NATURE AND EXTENT OF THE IDENTIFIED PROBLEM.

After validating that claims are being billed in error, target medical review activities at providers or services that place the Medicare trust funds at the greatest risk while ensuring the level of review remains within the scope of the budget for medical review; that is, does not vary widely from the level of review set out in the budget and performance requirements (BPRs). This will ensure resources are available to follow through with the PCA process for targeted providers or services. Ensure that actions imposed upon Medicare providers for failure to meet Medicare rules, regulations and other requirements are appropriate given the level of non-compliance (e.g., a small level of non-compliance would not warrant 100% prepayment medical review).

4. WHEN REQUESTING ADDITIONAL DOCUMENTATION FOR MEDICAL REVIEW PURPOSES, NOTIFY PROVIDERS THAT THE REQUESTED DOCUMENTATION IS TO BE SUBMITTED TO THE CONTRACTOR WITHIN 30 DAYS OF THE REQUEST.

However, if the documentation needed to make a medical review determination is not received within 45 days from the date of the documentation request, make a medical review determination based on the available medical documentation. Do not return the claim to the provider (RTP). If the claim is denied, deny payment or collect the overpayment. Fiscal intermediaries must reverse the claims denied on postpay review from the claims processing system so they do not appear on the Provider Statistical and Reimbursement Report.

5. THE PROVIDER ERROR RATE* IS AN IMPORTANT CONSIDERATION IN DECIDING HOW TO ADDRESS THE PROBLEM.

Other factors, though, deserve consideration as well--such as the total dollar value of the problem and past history of the provider. Assess the nature of the problem as minor, moderate or significant concerns and use available tools appropriate to characterization of the problem. The graphic attached (Exhibit 2) provides some vignettes for guidance on how to categorize and respond to varying levels of problems.

* For prepayment review, use the following formula to calculate the provider's service specific error rate:

$$\frac{\text{dollar amount of allowable}^{**} \text{ charges for services billed in error as determined by MR}^{***}}{\text{dollar amount of allowable}^{**} \text{ charges for services medically reviewed}}$$

For postpayment review, use the following formula to calculate the provider's service specific error rate:

$$\frac{\text{dollar amount of services paid in error as determined by MR}^{***}}{\text{dollar amount of services medically reviewed}}$$

**If allowable charges are not available, submitted charges may be used until system changes are made.

***Net out (subtract) the dollar amount of charges underbilled

6. PROVIDER FEEDBACK AND EDUCATION IS AN ESSENTIAL PART OF SOLVING PROBLEMS. When a widespread problem is identified affecting a large number of providers, solicit medical and specialty societies to help with educational efforts. See Exhibit 1 for additional interventions. When a problem is limited to a small group, provide feedback to providers on (1) the nature of the problems identified; (2) what steps they should take to address the problem; and (3) what steps you will take to address the problem. Focused provider education means direct 1:1 contact between you and the provider through a telephone contact, letter, or meeting. You must provide comparative data on how the provider varies from other providers in the same specialty payment area or locality. Graphic presentations may help to communicate the problem more clearly. The overall goal of providing feedback and education is to ensure proper billing practices so that claims will be submitted and paid correctly. Remove providers from medical review as soon as possible when they demonstrate compliance with Medicare billing requirements.

You must send written notification to all providers when they are placed on medical review and removed from medical review. We recognize that some providers may remain on medical review for long periods of time, despite your educational interventions and use of the PCA concepts. In the case of extended medical review activities, provide written notification at least every 6 months. Notification letters must be clear and concise and must include at least the following information: the reasons for medical review; previous review findings (if applicable); planned medical review (level of review and duration), potential for continuation of or increase in medical review levels (if identified problems continue, additional problems are identified, etc.); description of the specific actions the provider must take to resolve the problems identified in the medical review process; when appropriate, an offer to provide individualized education; and the name and telephone number of a contact person who is familiar with the contents of the notification letter. If a provider requests a meeting with you, you must make reasonable efforts to comply.

7. ALL OVERPAYMENTS IDENTIFIED MUST BE COLLECTED OR OFFSET, AS APPROPRIATE, AS DETERMINED BY HCFA DIRECTIVES AND YOUR OVERPAYMENT COLLECTION PROCEDURES.

8. AT ANY TIME, IF THE MEDICAL REVIEW DETECTS POSSIBLE FRAUD, REFER THE ISSUE TO THE FRAUD UNIT. PCA requirements do not apply when a fraud development is initiated.

9. TRACK INTERVENTIONS (REVIEWS AND EDUCATIONAL CONTACTS) WITH INDIVIDUAL PROVIDERS THROUGH A PROVIDER TRACKING SYSTEM (PTS). The PTS will identify all individual providers and track all contacts made as a result of actions to correct identified problems such as eligibility and medical necessity issues. Record the name of the person contacted in the PTS. Use the PTS to coordinate contacts with providers (e.g. medical review education contacts). If a provider is contacted as a result of more than one problem, ensure that multiple contacts are necessary, timely and appropriate, not redundant. Coordinate this information with your Fraud unit to assure contacts are not in conflict with fraud related activities.

The PTS should contain the date a provider is put on a provider specific edit for medical review.
Reassess

all providers on medical review quarterly to determine if their behavior has changed. Note the results of the quarterly assessment in the PTS. If the behavior has resolved sufficiently and the edit was turned off, note the date the edit was turned off in the PTS. When a provider appeals a medical review determination to the Administrative Law Judge (ALJ), share appropriate information in the PTS with the ALJ to demonstrate corrective actions that you have taken. This instruction does not alter the existing appeal process used by providers.

10. TRACK AND CONSIDER THE RESULTS OF APPEALS IN YOUR MEDICAL REVIEW ACTIVITIES. It is not an efficient use of medical review resources to deny claims that are routinely appealed and reversed. When such outcomes are identified, take steps to (1) understand why hearing or appeals officers viewed the case differently than you did; and (2) discuss appropriate changes in policy, procedure, outreach or review strategies with your regional office.

B. IMPLEMENTATION.--You must educate providers about the PCA concepts. At a minimum, publish an article about PCA in your next regularly scheduled provider bulletin. Include PCA as a regular part of your ongoing medical review training and new provider orientation training. In addition, request assistance from state medical societies to help with provider education.

NOTE: Provider includes physicians, suppliers, etc. A definition of provider can be found in the PIM Exhibit 1.

The *effective date* for this Program Memorandum (PM) is October 1, 2000.

To the extent possible, implement sections of this PM that do not require systems changes by October 1, 2000.

A separate PM will be sent indicating system implementation date.

These instructions should be implemented within your current operating budget.

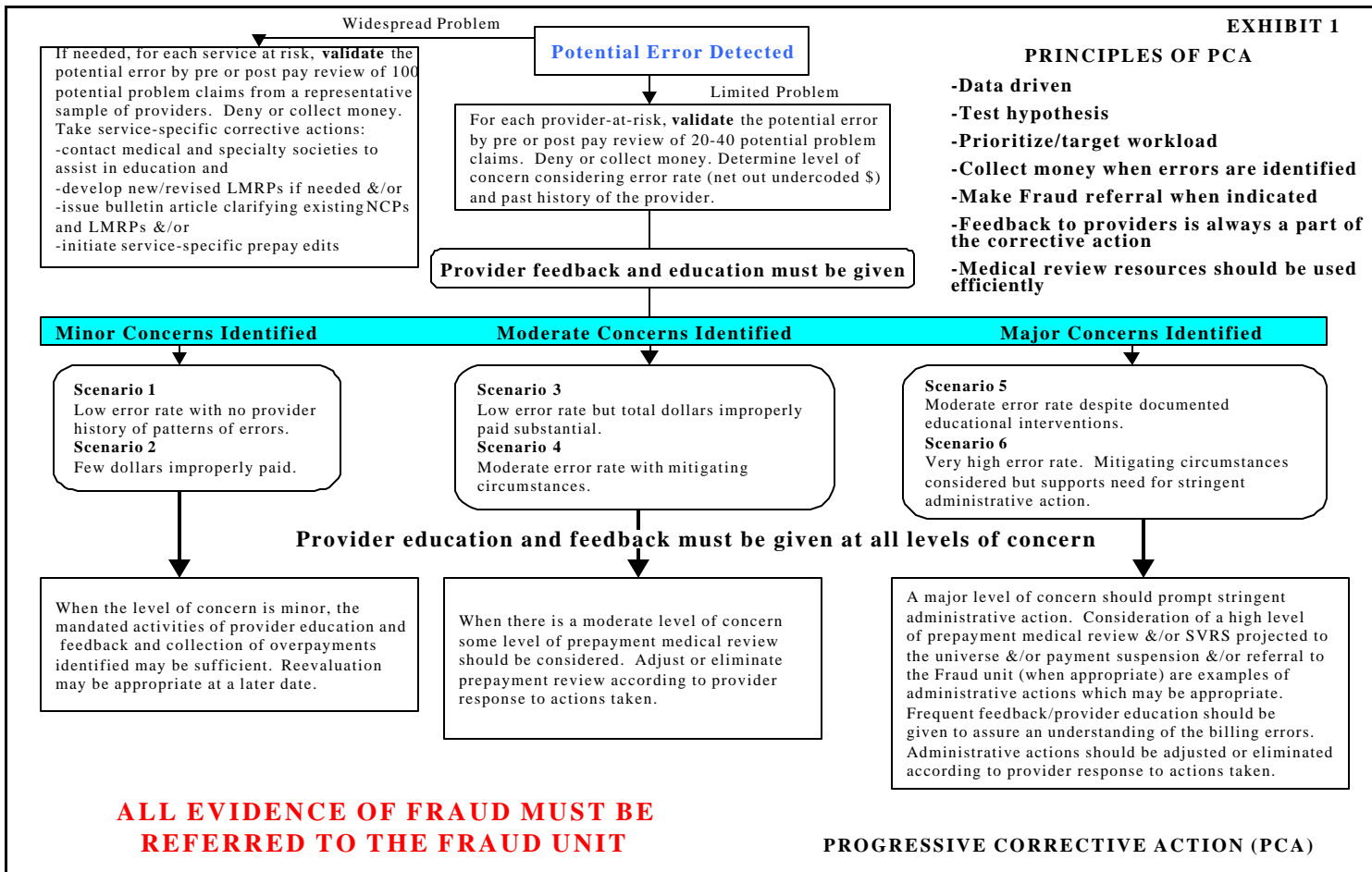
This PM may be discarded after January 1, 2002.

If you have any questions, contact Gina Perantoni at (410) 786-3219.

Attachments

PRINCIPLES OF PCA

- Data driven
- Test hypothesis
- Prioritize/target workload
- Collect money when errors are identified
- Make Fraud referral when indicated
- Feedback to providers is always a part of the corrective action
- Medical review resources should be used efficiently



ALL EVIDENCE OF FRAUD MUST BE REFERRED TO THE FRAUD UNIT

PROGRESSIVE CORRECTIVE ACTION (PCA)

EXHIBIT 2

The following are examples of vignettes that may result from medical review accompanied by suggested administrative actions. This information should be used only as a guide. It is not meant to be a comprehensive list of possible vignettes or an inclusive list of appropriate administrative actions.

1. Twenty claims are reviewed. One claim is denied because a physician signature is lacking on the plan of care. The denial reflects 7% of the dollar amount of claims reviewed. Judicious use of medical review resources indicates no further review is necessary at this time. Data analysis will determine where medical review activities should be targeted in the future.
2. Forty claims are reviewed. Twenty claims are for services determined to be not reasonable and necessary. These denials reflect 50% of the dollar amount of claims reviewed. 100% prepayment review is initiated due to the high number of claims denied and the high dollar amount denied.
3. Forty claims are reviewed. Thirty-five claims are denied. These denials reflect 70% of the dollar amount of claims reviewed. Payment suspension is initiated due to the high denial percentage and the Medicare dollars at risk.
4. Forty claims are reviewed. Thirty-three claims are denied. These denials reflect 25% of the dollar amount of the claims reviewed. The contractor provides feedback to the provider about specific errors made and educates the provider on the correct way to bill. The contractor initiates a moderate amount (e.g. 30%) of prepayment medical review to ensure proper billing.
5. Thirty-five claims are reviewed. Thirty claims are denied representing 75% of the dollar amount of the claims reviewed. Many of the denials are because services were provided to beneficiaries who did not meet the Medicare eligibility requirements. A consent settlement offer is made but declined by the provider. A SVRS postpayment review is performed and an overpayment is projected to the universe. Overpayment collection is initiated.
6. Twenty-five claims are reviewed. Five claims representing 5% of the dollar amount of the claims are denied. This supplier is known to the DMERC as one who has a significant decrease in billing volume when targeted medical review is initiated. The DMERC is concerned that this supplier may be selectively submitting bills when placed on medical review and chooses to continue some level of prepayment medical review despite the low error rate.

EXHIBIT 2 (Cont.)

7. Twenty claims are reviewed. Ten claims are denied for lack of complete physician orders representing 65% of the dollar amount of the claims. The RHHI informed the home health agency about the denials and the reason for the denials. In response, the agency owner initiated a mandatory training program for select staff. The HHA was put on 30% prepayment medical review. Results of the review indicated an improvement in the error rate to 30% (based on dollars denied divided by dollars reviewed). On appeal, nearly all of the denials were overturned. The RHHI consults with the ALJ to understand why the cases are being overturned and consults with the regional office on appropriate next steps.