PUBLICATION

CMS Limits MAC and QIC Scope of Review [Ober|Kaler]

2016

Medicare Administrative Contractors (MACs) and Qualified Independent Contractors (QICs) should not expand redeterminations and reconsiderations of claims denied on the basis of complex pre–or post–pay payments or automated post–payment reviews beyond the reason the claim or line item was initially denied, according to a new MLN Matters article (No. SE1521) revised on May 9.

CMS often uses MLN Matters articles to apprise providers of policy changes in the Medicare program. While providers will hail this change as good news, important limitations do apply. Providers should be attentive to the distinctions in the types of MAC and QIC reviews that may be subject to expansion despite this new guidance.

As an initial matter, while complex pre- and post-payment reviews and automated post-payment reviews are not subject to expansion, contractors may develop new issues and evidence for claims denied as a result of automated pre-payment review. Further, the guidance applies only to claims received after April 18, 2016. That is, prior determinations based on an expansion of the rationale for the initial claim denial will not be reopened as a result of this guidance. In addition, CMS notes that claims receiving a favorable appeal determination based on a limited review may still be subject to later adjustment as they progress through the system or system edits based on, for example, frequency limitations. Claims or line items denied in this manner would still receive full appeal rights.

Perhaps most notably, claims denied after review because providers failed to submit requested documentation, such as additional medical records, will still be subject to a full review of any applicable coverage requirements. This will include review for medical reasonableness and medical necessity. Thus, claims initially denied for insufficient documentation may still be denied for lack of medical necessity under the process outlined in the article.

Ober|Kaler's Comments

Providers concerned that MAC or QIC review of claims may lead to expansive reviews and denials based on difficult-to-discern rationales will be pleased by this guidance. However, because of the limitation on the subject matter for review, taken together with the possibility of later system edits leading to additional denials on the same claim, this process may also lead to increased congestion in the claims appeal process. Given the level of congestion with which providers are currently faced, this determination may be a mixed blessing.

Providers who receive requests for additional documentation should be careful to respond quickly and completely to such requests in order to forestall the possibility of expanded review of the whole claim. Additionally, it is important to be aware of the phase and type of review (e.g., pre- or post-payment, automated or complex) to which a claim is subject and, when determining whether to appeal, to take into account the possibility of subsequent system edits and denials. Providers should consult with counsel if they are uncertain what type of review is being applied to their claims.