

CLAIMS MONITORING SYSTEM (CMS) Q & A

WHAT IS THE CLAIMS MONITORING SYSTEM (CMS)?

The CMS is an automated claim selection program designed to constantly monitor the integrity of claims billed under the Medical Care Plan (MCP) through patient confirmation, examination of service documentation and comparison to the MCP Payment Schedule requirements.

WHO IS AFFECTED BY CMS?

All physicians who submit fee-for-service claims to MCP will be affected by this program.

WHEN WILL THE PROGRAM BECOME EFFECTIVE?

The program is scheduled to commence on November 16, 2006.

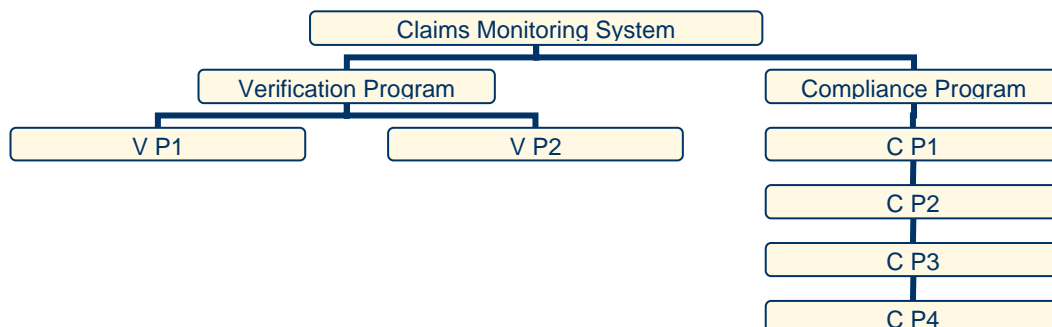
WHY IS CMS BEING IMPLEMENTED?

The CMS was developed following the final report of the Joint Department of Health & Community Services / Newfoundland and Labrador Medical Association Audit Review Committee which concluded its work in January 2003. The Committee felt that the focus of audits should involve assisting physicians, through education and feedback, in how to comply with the MCP Payment Schedule requirements.

This new system was designed to ensure that physicians are continuously aware of the elements required to substantiate MCP billings, resulting in fewer comprehensive audits.

HOW DOES THE PROGRAM WORK?

CMS consists of two separate programs – the Verification Program and the Compliance Program. All fee-for-service physicians initially enter the program in the first stage of the Verification Program (VP1).



Verification Program

Within the Verification Program, there are two separate and distinct stages. VP1 consists of a random electronic selection of one service for each physician per month (every two pay periods).

A physician who has acceptable records for three consecutive months will move to the second stage of the Verification Program (VP2) and will only be required to submit a record of service for one claim every third month (every six pay periods).

The physician is requested to submit the record of service to Audit Services within 14 days. The patient is simultaneously requested to verify the service billed.

The patient response and the physician record are reviewed by the audit staff for compliance with the MCP Payment Schedule.

A record which complies with the MCP Payment Schedule criteria is accepted and the claim is released for payment. Should a record not comply with the criteria, the claim is appropriately adjusted or cancelled and the physician is notified and instructed in proper documentation requirements.

A physician who has an unacceptable record in the Verification Program (either VP1 or VP2) will progress to the second program – the Compliance Program (CP), for the unacceptable fee code. The physician will also continue in the VP1 program.

Compliance Program

The Compliance Program consists of four separate and distinct stages. The first stage, CP1, will require a physician to submit 4 records of the identified fee code billed in a one month period – all of which must meet established criteria to exit from the Compliance Program.

Physicians enter the second stage, CP2, when there are deficiencies in any of the requested records from CP1. This stage will require the submission of 6 records of the identified fee code for review.

Physicians enter the third stage, CP3, when there are deficiencies in any of the requested records from CP2. This stage will require the submission of 10 records of the identified fee code for review. If deficiencies still occur at this stage, audit management will have the option to continue with CP3 until the problems are resolved or proceed to the next stage – CP4.

The fourth stage, CP4, involves a request for all records claimed by a physician for the identified fee code. The physician will remain in CP4 until all billing / documentation issues have been resolved.

At any stage in the Compliance Program, a physician with records that meet billing and document requirements will be removed from the Compliance Program.

If there are significant unsubstantiated claims after all these steps, a Comprehensive Audit may be carried out.

HOW WILL THE PHYSICIAN BE NOTIFIED TO SEND A RECORD?

An electronic notification in the form of a turn-around-document (TAD) will be sent to physicians requesting recent submission. Paper claim submitters will receive a request through the mail.

WILL THE PHYSICIAN RECEIVE FEEDBACK FROM THE REVIEW?

If a record is acceptable, the claim will be released for payment. If the record is not acceptable, the physician will receive electronic notification with reference to relevant Payment Schedule information to assist in proper billing / documentation techniques (mailed for paper claim filers).

WHAT IF THE PHYSICIAN IS UNABLE TO PROVIDE DOCUMENTATION WITHIN THE SPECIFIED TIME FRAME?

Should the physician be unable to provide documentation within the required time frame, Audit Services staff should be contacted. Note that failure to provide requested documents without providing a valid reason will result in claim cancellation and progression to the next stage of the program.

WHAT ARE THE BENEFITS OF CMS?

- CMS will not be an administrative burden to physicians as the sample sizes are low and no extrapolation is involved.
- CMS involves adjustments versus recoveries as claims are assessed based upon the physician-provided record prior to payment. Every opportunity is afforded to physicians to correct misbillings, and requests for records will decrease over time as record documentation improves.
- It is anticipated that the number of comprehensive audits will decrease through ongoing education in proper record documentation procedures.

CONTACT INFORMATION

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