CLINICAL CLAIM REVIEW

Provider Insight: Automatic Implantable Cardioverter Defibrillator Review

Automatic implantable cardioverter defibrillators (AICD) are life-saving devices and health plans want to ensure they are appropriately provided to those patients who truly need them most.

The AICD review ensures payments are consistent with the services provided.

An AICD is an electronic device designed to detect and treat life-threatening arrhythmias. Medicare coverage for AICDs is governed by a National Coverage Determination (NCD) from the Centers for Medicare and Medicaid Services (CMS) and therefore most payers follow CMS criteria. For those health plans with specific AICD policies that may differ from CMS, HMS will ensure reviews reflect the applicable policies.

For this review, we are verifying that ALL NCD criteria were met for placement of the device (or health plan criteria if different from CMS) and the services billed were coded accurately. During the review process HMS will:

- Verify clinical criteria are met and supported by the documentation
- Confirm the procedure is accurately coded
- Validate the waiting period criteria is met
- Ensure documentation requirements are met

The AICD review ensures payments are consistent with the services provided. If a review of the medical record confirms the waiting period requirement or other coverage criteria were not met, HMS identifies all costs associated with the procedure as an overpayment.

Our expert team of reviewers includes registered nurses, certified coders, and clinical auditors, along with physician reviewers. The team operates under the direction of the HMS chief medical officer and medical directors.

What to Expect if You've been Notified of an AICD Review

Claim audits are an important tool that health plans use to control cost and ensure compliance with regulations and policies. When submitted claims are selected for implantable cardioverter defibrillators reviews, you will receive a medical record request letter regarding medical records relevant to the claims in question.

The medical record request will include:

- Additional information on the audit being performed
- List of medical record documentation needed in order to complete the audit
- A time frame explaining when the medical record must be received
- Instructions on the best way to submit medical record documentation to HMS

The medical record request letter you receive will also include contact information for our Provider Relations team, who are ready to answer any questions and help with the audit process.

After the requested medical records are received, an experienced team of nurses and/or physicians will perform an in-depth review of the submitted documentation. The type of audit HMS conducts on any group of claims can vary and will be determined by the criteria set by the health plan. A determination will be made based on our findings, and a notice will be mailed to you with the results. If the notice is for an overpayment or inaccurate billing, we will provide the claim information and the rationale for the determination. It is possible you may disagree with the audit findings and rationale. Detailed instructions for appealing the determination are included.

Visit hms.com/cai today for questions about our clinical claims review process or if you have questions regarding a request for medical records request.

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