	<b>The Johns Hopkins Health System Policy &amp; Procedure</b>	<i>Policy Number</i>	FIN111
	<i>Subject</i> POLICY ON EXTERNAL FOCUSED MEDICAL REVIEW	<i>Effective Date</i>	08-01-01
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		<i>Revised</i>	5/15/07

*Revisions noted by vertical bar in right margin*

## **POLICY**

**This policy applies to the Johns Hopkins Health System Corporation (JHHS) and the following affiliated entities: The Johns Hopkins Hospital (JHH), Johns Hopkins Bayview Medical Center, Inc. (JHBMC), and Howard County General Hospital (HCGH).**

### **Purpose**

The purpose of this policy is to set forth the procedures that should be followed by JHH, JHBMC, or HCGH personnel whenever there is reason to believe that Medicare's fiscal intermediary has initiated a focused medical review of the respective hospital's claims.


A focused medical review is a process for reviewing Medicare claims that presents a potential risk of noncompliance. Generally, fiscal intermediaries can be instructed by the Center for Medicare and Medicaid Services (CMS) to conduct such focused medical reviews whenever national or local utilization and payment data suggest that medically unnecessary services are being ordered and provided.

The focused medical review may include suspending Medicare claims during the payment process to determine that the services identified, through diagnoses or procedure codes, are medically necessary. A focused medical review may also be initiated after payment has been made, by the intermediary conducting a random sample of claims. The claims are reviewed to determine if they meet the medical necessity guidelines and if the services were coded correctly. Post-payment reviews are generally used to identify not only medically unnecessary services but also potentially excessive services, by comparing a hospital's utilization pattern with those of other hospitals.

If warranted, corrective action can be implemented after billing problems are identified through the focused medical review process. This corrective action can include education of hospital personnel by the intermediary, conducting an overpayment assessment, or perhaps the intermediary referring the matter to the peer review organization, CMS or the Office of Inspector General.

When a focused medical review of claims is conducted, an initial request for documentation is sent by the fiscal intermediary to the hospital, usually accompanied by an additional development request letter. It is the policy of JHH, JHBMC, and HCGH to cooperate fully with the fiscal intermediary in providing the requested information within the specified timeframe. If a response is not provided within 30 days of receiving the request, the claim will be suspended and eventually denied. To ensure that complete information is provided on a timely basis, the following procedures are to be followed:

1. Upon receipt of the request letter, Patient Financial Services personnel shall immediately notify his or her immediate supervisor, who shall concurrently provide notification of the letter to the JHHS Billing Compliance Officer and to the applicable hospital's Medical Records Administrator.
2. The Compliance Department will evaluate the organization's risk based on the information outlined in the request letter and determine if an internal review shall be conducted prior to the submission of any records to the fiscal intermediary.
3. Upon notice from the Compliance Department, the Hospital shall submit a copy of any and all medical record documentation that is being requested in support of the claim.
4. All information shall be submitted before the due date specified in the request letter.

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If the claim(s) is ultimately denied, it is the responsibility of the hospital to implement the specific corrective action identified by the fiscal intermediary in order to avoid future denials and potential penalties.

**SPONSOR**

Vice President of Finance/Chief Financial Officer (CFO) and Treasurer, JHHS

**REVIEW CYCLE**

Three (3) years

**APPROVAL**

\_\_\_\_\_  
President, JHHS/JHH

\_\_\_\_\_  
Date