

**FY 2004 BUDGET AND PERFORMANCE REQUIREMENTS
MEDICARE INTEGRITY PROGRAM**

July 22, 2003

Medical Review (Carrier and DMERC)

Addendum 1

The Medical Review (MR) Budget and Performance Requirements (BPRs) reflect the principles, values, and priorities for the Medicare Integrity Program (MIP). Program Integrity's primary principle is to pay claims correctly. In order to meet this goal, carriers and DMERCs must ensure that they pay the right amount for covered services, rendered to eligible beneficiaries, by legitimate providers. CMS follows four parallel strategies that assist us in meeting this goal:

- preventing inappropriate payments through effective enrollment of providers and beneficiaries;
- detecting program aberrancies through on-going on data analysis;
- coordinating and communicating with our partners, including contractors, law enforcement agencies, and others; and
- reasonable and firm enforcement policies in accordance with the principles of Progressive Corrective Action (PCA).

Medical Review's primary mission is to reduce the claims payment error rate. The MR staff has a variety of tools to use in support of their mission. Primarily, MR reduces the error rate by identifying patterns of inappropriate billing, educating providers about Medicare coverage and coding requirements, and performing medical review.

For FY 2004, CMS is providing instructions for the MR and Local Provider Education and Training (LPET) programs, through two BPRs documents: the MR BPRs and the LPET BPRs. These BPRs will provide instructions for the MR program and MR/LPET strategy. The BPRs require carriers and DMERCs to design a single MR/LPET strategy. Carriers and DMERCs are expected to design one MR/LPET strategy document that will satisfy the MR/LPET strategy requirements for both BPRs. Please refer to the instructions in the LPET BPRs for additional guidance in strategy design. Carriers and DMERCs that conduct MR activities at multiple sites must have a system in place that allows workload and funding to be tracked separately for each individual MR activity site. These carriers and DMERCs may develop only one MR/LPET strategy; however site-specific problem identification, prioritization, funding, and workload must be addressed in the strategy and reported with the Interim Expenditure Report in the remarks section of CAFM II for each activity code (PIM Chapter 1, Section 2f). Negotiations with the RO budget and MR staff will concern the strategy and the individual elements of the strategy. RO budget and MR staff retain the authority to reduce contractor's funding amounts for MR strategies that are not detailed in their methodology, funding, or selection of activities for reducing the claims payment error rate.

The MR/LPET strategy must address identified medical review issues, educational activities, projected goals, and the evaluation of educational activities and goals. It must be a fluid document that is revised, as targeted issues are successfully resolved, and other issues take precedence. The initial step in designing the MR/LPET strategy requires carriers and DMERCs to gather and analyze information and data from various sources. The carriers and DMERCs must develop methods of communication with various operational areas that interact with MR. Information collected as a result of communication with the carriers' and DMERCs' other operational areas includes, but is not limited to, trends in appeals and provider inquiry. Data collection should include, but is not limited to, the data analysis of medical review, Provider Communications (PCOM), and data from the review of claims.

After information and data is gathered and analyzed, the carriers and DMERCs must develop and prioritize a medical review problem list. A problem list is a list of the program vulnerabilities that threaten the Medicare Trust Fund that can be addressed through MR and LPET activities. Carriers and DMERCs must consider resources and the scope of each identified medical review issue, when prioritizing their problem list. Once a problem list is created, the carriers and DMERCs must develop MR interventions, using the philosophy of PCA, to address each problem. The methods and resources used for the MR and LPET interventions depend on the scope of the problems identified and the level of education needed to successfully address the problems.

The carriers and DMERCs must develop multiple tools to effectively address the local Medicare providers' variety of educational needs. The MR/LPET strategy must include achievable goals and evaluation methods that test the effectiveness and efficiency of educational activities designed to resolve targeted medical review problems. In addition, as problems are successfully addressed, the MR/LPET strategy must incorporate processes for follow-up that ensure appropriate resolution of the issue. As issues are resolved, the carriers and DMERCs should continue to address other issues identified on the problem list.

The MR/LPET strategy must include a section that describes the process used to monitor spending in each activity code. The process must ensure that spending is consistent with the allocated budget and includes a process to revise or amend the plan when spending is over or under the budget allocation. In addition, the strategy must describe how workload for each activity code is accurately and consistently reported. The workload reporting process must also assure proper allocation of employee hours required for each activity.

Finally, the MR/LPET strategy must include a mechanism utilized to monitor and improve the accuracy and consistency of the MR staff's responses to specific inquiries regarding coverage and coding issues, whether they are written or by telephone. This is to ensure that providers receive accurate and consistent answers to their Medicare claim questions.

In addition to the review of claims, local provider education is a critical tool in reducing the claims payment error rate. Therefore, contractors may need to supplement the LPET budget with MR funds. All MR education activities are funded through LPET.

In FY 2004, MR will continue to incorporate Activity Based Costing (ABC) in the budget process. ABC is a management reporting system that will allow the MR department to focus on the costs of the work activities, instead of concentrating on the standard cost centers associated with the traditional cost accounting structure. ABC identifies the all-inclusive business process for each activity, so that the total costs of the activity are fully visible to the MR manager. Business processes are defined for each MR activity code and are included as Attachment 2 to the BPRs. MR managers should identify only those costs associated with each activity code definition, in order to assure the integrity of the ABC process.

In addition to satisfying all requirements contained in the MR BPRs, carriers and DMERCs must carry out all medical review activities identified in the Program Integrity Manual (PIM) and all relevant medical review Program Memoranda.

Submit a MR/LPET Strategy to the Regional Office and to the Central Office mailbox at MRSTRATEGIES@cms.hhs.gov with your Budget Request. Contractors will be given a specified budget for MR. Based on this budget the contractor is asked to develop a unique MR strategy within their jurisdiction. This strategy must be consistent with the goal of reducing the error rate. Submit a quarterly strategy update that assesses the accomplishments of individual elements of the strategy, as well as other components of the MR/LPET process, at the end of each quarter, to the Regional Office and Central Office mailbox.

Activities in the MR BPRs will be reflected in updated PIM transmittals prior to the start of the fiscal year.

Discontinued MR Activities

In FY 2004, CMS will no longer fund the following activity:

CAFM II reporting for Activity Code 21030 - Routine Manual Postpay Review

CAFM II reporting for Activity Code 21031 - Complex Manual Provider-Specific Postpay Review

CAFM II reporting for Activity Code 21032 - Complex Manual Service-Specific Postpay Review

CAFM II reporting for Activity Code 21201 - Prepay Complex Manual Probe Sample Review

CAFM II reporting for Activity Code 21202 - Prepay Complex Manual Provider-Specific Review

CAFM II reporting for Activity Code 21203 - Prepay Complex Manual Service-Specific Review

CAFM II reporting for Activity Code 21205 - Postpay Complex Manual Probe Sample Review

CAFM II reporting for Activity Code 21209 - Corporate Activities

Continuing MR Activities

In FY 2004, carriers and DMERCs are expected to continue to perform the range of activities in the PIM including, but not limited to: developing an MR/LPET strategy, performing data analysis; conducting probe reviews; performing the appropriate levels of prepayment and postpayment medical reviews; developing and revising Local Medical Review Policy (as appropriate); and supporting Program Safeguard Contractor activities.

New MR Activities

In FY 2004, carriers and DMERCs must begin performing the following activities:

*Reporting for Advance Determinations of Medicare Coverage (ADMC)
(Miscellaneous Code 21221/01) (DMERCs Only)*

Reporting for Medical Review Reopenings (Activity Code 21210)

Reporting for Complex Manual Probe Sample Review (Activity Code 21220)

Reporting for Prepay Complex Manual Review (Activity Code 21221)

Reporting for Postpay Complex Manual Review (Activity Code 21222)

Quantifiable MR Activities

Instructions for completing the following quantifiable MR Activities can be found in the PIM, Chapter 11. Carriers and DMERCs must follow the instructions in the PIM when performing and reporting the costs and workloads associated with the following activities:

Automated Review (Activity Code 21001)

PIM Ch. 3, § 5.1; PIM Ch. 11, § 1.3.1

Routine Manual Reviews (Activity Code 21002)

PIM Ch. 3, § 5.1; PIM Ch. 11, § 1.3.2

Data Analysis (Activity Code 21007)

PIM Ch. 2, § 2; PIM Ch. 11, § 1.4

Program Safeguard Contractor (PSC) Support Services (Activity Code 21100)

Contractors must track and record costs associated with providing support to PSC that support Medical Review (e.g. working with the CERT contractor, or PSC doing MR or data analysis for MR). This activity code does not include providing support for the BI PSC, charge these costs to Activity Code 23201.

PIM Ch. 11, § 1.8

Policy Reconsideration/Revision Activities (Activity Code 21206)

PIM Ch. 11, § 1.5.2

MR Program Management (Activity Code 21207)

MR Program Management encompasses managerial responsibilities inherent in managing MR and LPET, including: development, modification, and periodic reporting of MR/LPET strategies and quality assurance activities; planning, monitoring, and adjusting workload performance; budget-related monitoring and reporting; and implementation of CMS instructions.

Activity Code 21207 is designed to capture the costs of managerial oversight for the following tasks:

- Develop and periodically modify MR/LPET strategy;
- Develop and modify quality assurance activities, including special studies, Inter-Reviewer Reliability testing, committee meetings, and periodic reports;
- Evaluate edit effectiveness;
- Plan, monitor, and oversee budget, including interactions with contractor budget staff and RO budget and MR program staff;
- Manage workload, including monitoring of monthly workload reports, reallocation of staff resources, and shift in workload focus when indicated;
- Implement MR instruction from regional and/or central office; and
- Educate staff on MR issues, new instructions, and quality assurance findings.

PIM Ch. 11, § 1.9

New Policy Development Activities (Activity Code 21208)

PIM Ch. 11, § 1.5.1

Medical Review Reopenings of N102 Claims and Claims with Late Documentation (Activity Code 21210)

When conducting a complex medical review on a claim, it is often necessary for contractors to send physicians, providers, or suppliers, additional documentation requests (ADRs). Generally, an ADR is made to assist the contractor in determining if payment of the claim is reasonable and necessary. Physicians, providers, or suppliers are given 45 days to respond to ADRs. If the ADR is not responded to in a timely manner, contractors must determine if the claim is reasonable and necessary, based on the existing information. Since ADRs are generally sent only when the record contains little or no evidence to support paying the claim, failure to respond to an ADR usually results in a claim denial. These claim denials are issued with Remittance Advice Code N102 (“Denied due to failure to submit necessary medical documentation.”).

Many times, the documentation arrives after the 45-day period or the physician, provider, or supplier submits the requested documentation along with a request for an appeal of the claim denial. As a result, it is the Appeals Unit, rather than the MR Unit that reviews the requested documentation. We believe the MR Unit should have the first opportunity to examine the documentation they requested in the ADR, and issue a revised determination based on that documentation.

Therefore, when an N102 claim denial is appealed and the documentation requested is received after the 45-day deadline, or is received with the appeal request, the MR Unit will review the requested documentation as opposed to the Appeals Unit. The Appeals Unit will forward the file based on which unit issued the N102 denial (i.e., MR issued the denial, MR will receive the forwarded file and conduct the review).

In the workload section of CAFM II, Activity Code 21210, carriers and DMERCs must capture the number of reopening requests received in Workload 1; the number of reopening requests resulting in payment in Workload 2; and, to the extent possible, the number of providers requesting a reopening in Workload 3.

Complex Manual Probe Sample Review (Activity Code 21220)

Report all costs associated with prepay and postpay Complex Manual Probe Sample Review in Activity Code 21220. In the workload section of CAFM II, Activity Code 21220, report the number of claims reviewed in Workload 1. Report the number of claims denied in whole or in part in Workload 2. To the extent the carrier and DMERC can report providers subjected to complex review, they should report this number as Workload 3.

Prepay Complex Manual Review (Activity Code 21221)

Report all costs associated with Prepay Complex Manual Review in Activity Code 21221. In the workload section of CAFM II, Activity Code 21221, report the number of claims reviewed in Workload 1. Report the number of claims denied in whole or in part in Workload 2. To the extent the carrier and DMERC can report providers subjected to complex review, they should report this number as Workload 3.

Advance Determinations of Medicare Coverage (ADMC)
(Miscellaneous Code 21221/01)

DMERCs are to report all costs associated with performing Advance Determinations of Medicare Coverage (ADMC) in Miscellaneous Code 21221/01. DMERCs are to report the number of ADMC requests accepted.

PIM Ch. 5, § 7

Postpay Complex Manual Review (Activity Code 21222)

Contractors must report all costs associated with Postpay Complex Manual Review in Activity Code 21222. In the workload section of Activity Code 21222, contractors must report the total number of claims reviewed on a postpayment basis as Workload 1 and report the total number of claims denied in whole or in part as Workload 2. To the extent contractors can report providers subjected to postpayment review, they should report this number as Workload 3.

MEDICAL REVIEW DELIVERABLES

<i>Report</i>	<i>Due date(s)</i>	<i>Submitted to</i>
MR/LPET Strategy (Note: Contractors operating multiple MR/LPET sites are NOT required to submit separate reports; however, consolidated reports must clearly identify the costs and workloads attributable to each site)	Submit with Budget Request	Regional Office <i>MRSTRATEGIES</i> <i>@cms.hhs.gov</i> (must be submitted via the VP of Government Operations)
MR/LPET Strategy Update	Submit with quarterly IER (i.e. for FY 2004, January 20, April 20, July 20)	Regional Office <i>MRSTRATEGIES</i> <i>@cms.hhs.gov</i> (must be submitted via the VP of Government Operations)