CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 174	Date: NOVEMBER 17, 2006
	Change Request 5275

NOTE: Transmittal 170, dated November 3, 2006, is being rescinded and replaced with Transmittal 174, dated November 17, 2006. The only change is in the language in the note below. All other material remains the same.

NOTE: Transmittal 163, dated September 29, 2006 is rescinded and replaced with Transmittal 170, dated November 3, 2006. This transmittal corrects a requirement that MACs and PSCs report educational activities in a POE activity code. Business Requirement 5275.20 and manual section 11.1.3.3 have been revised, to state that this activity is no longer to be reported in an MR activity code, rather than specifically instructing that it be reported in a POE activity code. The clarification to Business Requirement 5275.21 indicates that DME MACs will not be responsible for this work until such time as it is incorporated into their SOWs. All other information remains the same.

SUBJECT: Transition of Medical Review Educational Activities

I. SUMMARY OF CHANGES: With a shift in funding for Local Provider Education and Training (LPET) from medical review (MR) to Provider Outreach and Education (POE), effective October 1, 2006, new guidelines for the delivery of education are required. Various sections in this chapter were deleted and the existing policy was renumbered and rearranged into new sections.

NEW / REVISED MATERIAL
EFFECTIVE DATE: OCTOBER 1, 2006
IMPLEMENTATION DATE: OCTOBER 6, 2006

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	1/Table of Contents
R	1/1.1/Introduction
R	1/1.1.2/Types of Claims for Which Contractors Are Responsible
R	1/1.2.1/Goal of MR Program
R	1/1.2.2/MR Manager
R	1/1.2.3/Annual MR Strategy
R	1/1.2.3.1/Data Analysis and Information Gathering

R	1/1.2.3.2/Problem Identification & Prioritization
R	1/1.2.3.3/Intervention Planning
R	1/1.2.3.4/Program Management
R	1/1.2.3.5/Budget and Workload Management
R	1/1.2.3.6/Staffing and Workforce Mnagement
R	1/1.4/Contractor Medical Director (CMD)
D	1/1.4.1/LPET Activities
D	1/1.4.1.1/One-on-One Provider Education
D	1/1.4.1.2/Education Delivered to a Group of Providers
D	1/1.4.1.3/Education Delivered Via Electronic Media
D	1/1.4.2/Description of Methods of Education
D	1/1.4.2.1/Proactive Local Education
D	1/1.4.2.2/Comprehensive Education Interventions
D	1/1.4.2.3/Comparative Billing Report Education
D	1/1.4.2.4/Frequently Asked Questions Regarding Local Education Issues
D	1/1.4.2.5/Bulletin Articles/Advisories Regarding Local Education Issues
D	1/1.4.2.6/Scripted Response Documents on Local Education Issues
D	1/1.4.3/LPET Staff
R	1/1.5/Maintaining the Confidentiality of MR Records
D	1/1.6/Maintaining The Confidentiality of Medical Records
R	3/Table of Contents
R	3/3.1/Introduction
R	3/3.1.1/Provider Tracking System (PTS)
R	3/3.1.2/Evaluating the Effectiveness of Corrective Actions
R	3/3.2/Verifying Potential Error and Setting Priorities
R	3/3.2.1/Determining Whether a Problem is Widespread of Provider-Specific
R	3/3.2.2/Administrative Relief from Medical Review in the Presence of Disaster
R	3/3.3/Articles
D	3/3.3.1/Articles

R	3/3.4/Overview of Prepayment and Postpayment Review for MR Purposes
R	3/3.4.1.2/Additional Documentation Requests (ADR) During Prepayment or Postpayment MR
R	3/3.4.2/Denials Notices
R	3/3.4.4/Internal MR Guidelines
R	3/3.4.5/Types of Prepayment and Postpayment Review
R	3/3.4.6/Spreading Workload Evenly
R	3/3.5.1.1/Prepayment Edits
R	3/3.5.2/Categories of MR Edits
R	3/3.5.3/CMS Mandated Edits
R	3/3.6.3/Re-Adjudication of Claims
R	3/3.11.1.1/Review of Data
R	3/3.11.1.6/Provider Notification and Feedback
R	3/3.11.1.8/Fraud
R	3/3.11.1.9/Track Interventions
R	3/3.11.2/Implementation
R	3/3.11.3/Vignettes
R	4/4.2.2.4/Procedural Requirements
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R	7/7.2.8.1/Definition
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R	11/11.1.3/CAFM II Reporting for MR Activities

R	11/11.1.3.3/Data Analysis Cost (Activity Code 21007)
R	11/11.1.3.6/MR Program Management Costs (Activity Code 21207)
R	11/11.1.4/MIP Comprehensive Error Rate Testing (CERT) Support
R	13/13.9/Provider Education Regarding LCDs

III. FUNDING:

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Unless otherwise specified, the effective date is the date of service.

Attachment - Business Requirements

Pub. 100-08	Transmittal: 174	Date: November 17, 2006	Change Request 5275

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I. GENERAL INFORMATION

A. Background: With a shift in funding for local provider education and training (LPET) from medical review (MR) to provider outreach and education (POE), effective October 1, 2006, new guidelines for the delivery of education are required. Communication between the MR and POE departments, as well as with the program safeguard contractor (PSC) benefit integrity (BI) units will be integral to the goal of the MR program, to reduce the payment error rate. This CR also contains changes to language to reflect the transition from local medical review policies to local coverage determinations (LCDs), as well as the ongoing transition from fiscal intermediaries (FIs) and carriers to Medicare Administrative Contractors (MACs) and from durable medical equipment regional carriers (DMERCs) to durable medical equipment medicare administrative contractors (DME MACs). There are also deletions of some effective dates which occur in the past.

B. Policy: The LPET program will no longer exist in its previous form. Provider notification of findings and answering of questions directly related to an MR probe or complex medical review or to the clinical reasoning behind an LCD will continue to be performed by the MR department at the FI, carrier, MAC, and PSC with MR function. All other provider education, will be performed by the POE departments at the FI, carrier, MAC, and DMERC. All contractors performing MR functions shall work with POE to develop a method for communication regarding the disposition of cases referred by MR to POE for possible educational intervention.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)					
		FI	RH	Ca	DM	Shared System Maintainers	Other

						FISS	MCS	VMS	CWF	A/B MAC	DME MAC	A/B PSC	DME PSC
5275.1	The contractor shall no longer perform LPET as part of the medical review program.	X	X	X								X	X
5275.2	The contractor shall no longer include LPET as part of the annual MR strategy.	X	X	X								X	X
5275.3	The contractor shall no longer report work in activity code 24116- Provider Education.	X	X	X									
5275.4	The contractor shall no longer report work in activity code 24117- Education delivered to a group of providers.	X	X	X									
5275.5	The contractor shall no longer report work in activity code 24118- Education delivered via electronic or paper media.	X	X	X									
5275.6	The contractor, MAC, and PSC shall develop a method of effective communication with POE regarding the disposition of MR cases referred to POE for potential educational intervention.	X	X	X						X		X	X
5275.7	The contractor, MAC, and PSC shall include identified MR problems, MR activities, projected goals, and the evaluation of activities and goals in the annual MR strategy.	X	X	X						X		X	X
5275.8	The contractor, MAC, and PSC shall develop a method to communicate with POE regarding the disposition of cases referred for potential intervention.	X	X	X						X		X	X
5275.9	The contractor, MAC, and PSC shall incorporate a process for follow-up on cases referred to POE for potential educational intervention into the communication method.	X	X	X						X		X	X

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)											
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other			
						FISS	MCS	VMS	CWF	A/B MAC	DME MAC	A/B PSC	DME PSC
5275.10	The contractor shall ensure that POE staff have ready access to copies of provider notification letters sent by MR to providers.	X	X	X						X		X	X
5275.11	The contractor, MAC, and PSC shall include in the notification letter the name and contact information for the POE department for follow-up education, where it is offered in the letter.	X	X	X						X		X	X
5275.12	The contractor, MAC, and PSC shall make a priority referral to POE for medium or high priority problems identified through MR.	X	X	X						X		X	X
5275.13	The contractor, MAC, and PSC shall make a priority referral to POE for problems which, on follow up data analysis, have not improved through MR or POE activities.	X	X	X						X		X	X
5275.14	The contractor, MAC, and PSC shall utilize the PTS to record contacts with providers including, but not limited to MR notifications, communications directly related to probe or complex medical review, and referrals to POE.	X	X	X						X		X	X
5275.15	The contractor, MAC, and PSC shall communicate with specific providers, through the MR department, about aspects of PCA performed by MR.	X	X	X						X		X	X
5275.16	DME PSC BI units shall coordinate and communicate with the MR unit within their organization to avoid duplication of effort.												X
5275.17	A/B PSC BI units shall coordinate and communicate with the MR units in the ACs and MAC to avoid duplication of effort.											X	

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)											
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other			
						FISS	MCS	VMS	CWF	A/B MAC	DME MAC	A/B PSC	DME PSC
5275.18	The PSCs shall include in their Joint Operating Agreement coordination on POE with ACs and MACs.											X	X
5275.19	The contractor should share with POE any MR findings or clarifications which might be appropriate for Web-based Q&As or widespread education.	X	X	X						X		X	X
5275.20	Contractors shall not report analysis of data to develop and deliver educational interventions in an MR activity code.	X	X	X									
5275.21	The contractor, MAC, and PSC shall educate the provider community on new or significantly revised LCDs through POE.	X	X	X						X	X		
5275.22	The contractor, MAC, and PSC shall charge ONLY those responses to LCD inquiries of a clinical nature, such as LCD rationale, to MR.	X	X	X						X			X

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	None.									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	Instructions
5275.21	DME MACs are to follow the PIM to the extent outlined in their respective statements of work. This requirement will not apply to DME MACs until such time as the work is incorporated into their contracts.

B. Design Considerations: N.A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: The LPET activity codes 24116, 24117, and 24118 shall no longer be used.

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: October 1, 2006 **Implementation Date:** October 6, 2006 **Pre-Implementation Contact(s):** Kim Spalding kimberly.spalding@cms.hhs.gov **Post-Implementation Contact(s):** Regional offices	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.**

***Unless otherwise specified, the effective date is the date of service.**

Medicare Program Integrity Manual

Chapter 1 - Overview of Medical Review (MR) and Benefit Integrity *(BI) Programs*

Table of Contents
(Rev.174, 11-17-06)

1.1- Introduction

(Rev.174, Issued: 11-17-06, Effective: 10-01-06, Implementation: 10-06-06)

The Program Integrity Manual (PIM) reflects the principles, values, and priorities for the Medicare Integrity Program (MIP). The primary principle of Program Integrity (PI) is to protect the Medicare Trust Fund from fraud, waste and abuse. In order to meet this goal, contractors must ensure that they pay the right amount for covered and correctly coded services rendered to eligible beneficiaries by legitimate providers. The Centers for Medicare & Medicaid Services (CMS) follows four parallel strategies in meeting this goal: 1) preventing fraud through effective enrollment and through education of providers and beneficiaries; 2) early detection through, for example, medical review and data analysis; 3) close coordination with partners, including contractors and law enforcement agencies; and 4) fair and firm enforcement policies.

Fiscal intermediaries (FIs), carriers, regional home health intermediaries (RHHIs), durable medical equipment regional carriers (DMERCs) shall follow the entire PIM for medical review functions as they relate to their respective roles and areas of responsibility to medical review (MR).

Part A and B Medicare administrative contractors (A/B MACs) and durable medical equipment medicare administrative contractors (DME MACs) shall follow the PIM to the extent outlined in their respective statements of work. Program safeguard contractors (PSCs) and durable medical equipment program safeguard contractors (DME PSCs) shall follow the PIM to the extent outlined in the umbrella program safeguard contractor statement of work and in their respective task order statements of work. The PSC, in partnership with CMS, shall be proactive and innovative in finding ways to enhance the performance of PIM guidelines.

There are three types of entities with which Medicare contracts to review, and process claims. From this point forward, the term "contractors" shall refer to all of the following, unless otherwise noted:

- *Affiliated contractors (ACs), which include FIs (including RHHIs), carriers, and DMERCs,*
- *Medicare admistrative contractors (MACs), which include A/B MACs and DME MACs, and*
- *Program safeguard contractors (PSCs), which include A/B pscs and DME PSCs.*

The PIM supports the Government Performance Results Act (GPRA) and OMB's Program Assessment Rating Tool (PART). The GPRA requires contractors to reduce the error rates as identified in the chief financial officer's (CFO) audit and developed through the comprehensive error rate testing (CERT) program.

The CMS' national objectives and goals as they relate to medical review are as follows: 1) Increase the effectiveness of medical review payment safeguard activities; 2) Exercise accurate and defensible decision making on medical review of claims; *and 3)* Collaborate with other internal components and external entities to ensure correct claims payment, and to address situations of fraud, waste, and abuse. In order to ensure these objectives are being met, CMS has developed the S.P.A.C.E. Program to evaluate contractor performance. The S.P.A.C.E. acronym identifies the following key components of this evaluation strategy:

- **Self-Assessment** (Certification Package for Internal Controls (CPIC)**:** This is a self-certification process in which a contractor performs a risk assessment to identify and select particular business function areas to thoroughly evaluate and find areas for improvement.

- **Performance Oversight** (Statement of Auditing Standards (SAS 70) Audit): The SAS-70 is a process currently utilized by Medical Review (MR) and other CMS components for contractor performance oversight. This performance oversight program utilizes the skills and expertise of independent auditors to complete a performance audit. The audit takes approximately four months to complete and the contractor's performance during the most recent two quarters of the fiscal year are evaluated. There are two types of SAS-70 audits. Type I audits determine if essential internal controls are in place. Type II audits determine if the internal controls are effective. Medical review internal control objectives can be found in chapter 7 of the Medicare Financial *Management* Manual. The internal control objectives reflect CMS' requirements for an effective medical review operation.

And

- **Comprehensive Error Rate Testing** (CERT): CERT is a CMS program that measures a contractor's payment error rate. The S.P.A.C.E. program considers a

contractor's CERT score in conjunction with SAS-70 audit findings and CPICs when making an overall determination of a contractor's educational need.

- **Educational Training Program**: Regional office (RO) or central office (CO) staff may recommend an educational intervention for a contractor based on findings from a SAS-70 audit, problems with a contractor's medical *review (MR)* Strategy, or for other concerns the RO or CO staff may have. A problem-focused educational interaction between CMS staff (RO & CO) and a contractor is based on potential or current areas of contractor vulnerability.

The PIM requirements form the basis of CMS' S.P.A.C.E. Program oversight. The PIM serves as the foundation upon which MR internal control objectives are developed. These internal control objectives are the criteria against which the contractor is evaluated when performing a self-assessment and/or during the SAS 70 Audit. The PIM also serves as written guidance for contractor evaluation under the Comprehensive Error Rate Testing Program, which serves to ensure that contractors are exercising accurate, and defensible decision making on medical reviews.

Both MR and the BIU use data analysis as the foundation for detection of aberrant billing practices. Through data analysis, the MR unit determines the extent of the problem and the potential threat to the Medicare Trust Fund. The most egregious problems are selected for validation by probe review. The results of the probe review will determine whether the problem is an unintentional error by the billing entity that will be pursued by the MR unit; or potentially fraudulent, which is pursued by the BIU; or determined not to be a problem.

The purpose of this chapter is to describe the *MR purpose*, functions, and requirements.

1.1.2 - Types of Claims for Which Contractors Are Responsible

(Rev.174, Issued: 11-17-06, Effective: 10-01-06, Implementation: 10-06-06)

Contractors may perform MR functions for the following types of claims:

- All claims appropriately submitted to a Medicare fiscal intermediary (FI), carrier, durable medical equipment regional carrier (DMERC), *or Medicare Administrative Contractor (MAC)*, and;

- All claims appropriately submitted to an intermediary including but not limited to:

  - Acute Care Inpatient Prospective Payment System (PPS) hospital swing beds;
  - Ambulatory surgical centers (hospital based);
  - Inpatient rehabilitation freestanding hospitals or excluded rehabilitation units of PPS hospitals;
  - Inpatient critical access hospitals including swing beds;
  - Inpatient psychiatric freestanding hospitals or excluded psychiatric units of PPS hospitals; and
  - All ESRD facilities (freestanding and hospital based).

Prior to implementing medical review, contractors shall notify providers their claims will be subject to review. Contractors shall apply progressive corrective action in review of these claims.

Due to the quality improvement organizations (QIOs) performing reviews, contractors shall not perform MR functions for:

- Acute care inpatient PPS hospital (DRG) claims; and
- Long term care hospital (LTCH) claims

Contractors shall include claims from the above settings in doing data analysis to plan their medical review strategy using the same criteria employed in other settings. Amendments to plans and strategies shall be made as needed if analysis indicates adjustment of priorities.

As part of your annual review local coverage determinations (LCDs) in conformance with IOM Pub.100-8, chapter 13, section 13.3, consider the need to modify your policies to apply to these settings. As in any setting, contractors shall provide educational opportunities to assure knowledge of applicable policies and appropriate billing procedures.

1.2.1 - Goal of MR Program

(Rev.174, Issued: 11-17-06, Effective: 10-01-06, Implementation: 10-06-06)

Under GPRA, CMS has a goal to reduce the Medicare fee-for-service paid claims error rate. Contractors are not required to establish a baseline error rate or calculate a contractor specific error. The CERT Program will provide the baseline measurements. The goal of the MR program is to reduce payment error by identifying and addressing billing errors concerning coverage and coding made by providers. To achieve the goal of the MR program, contractors:

- Proactively identify potential MR related billing errors concerning coverage & coding made by providers through analysis of data. (e.g., profiling of providers, services, or beneficiary utilization) and evaluation of other information (e.g., complaints, enrollment and/or cost report data) (IOM Pub.100-08, chapter 2, describes these activities in further detail.);

- Take action to prevent and/or address the identified error. Errors identified will represent a continuum of intent; (IOM Pub.100-08, chapter 3, describes these actions in further detail.)

- Place emphasis on reducing the paid claims error rate by *notifying* the individual billing entities (i.e., providers, suppliers, or other approved clinician) *of MR findings and making appropriate referrals to Provider Outreach and Education (POE), and PSC Benefit Integrity (BI) units*; and

- Publish LCDs to provide guidance to the public and medical community about when items and services will be eligible for payment under the Medicare statute.

Providers may conduct self-audits to identify coverage and coding errors using the Office of Inspector General (OIG) Compliance Program Guidelines at http://www.os.dhhs.gov/oig/modcomp/index.htm. Contractors must follow IOM Pub. 100-08, chapter 4, section 4.16, in handling any voluntary refunds that may result from these provider self-audits.

Most errors do not represent fraud. Most errors are not acts that were committed knowingly, willfully, and intentionally. However, in situations where a provider has repeatedly submitted claims in error, the MR unit shall follow the procedures listed in IOM Pub.100-08, chapter 3, §3.1. For example, some errors will be the result of provider misunderstanding or failure to pay adequate attention to Medicare policy. Other errors will represent calculated plans to knowingly acquire unwarranted payment. See IOM Pub. 100-08, chapter 4, §2.1. Contractors shall take action commensurate with the error made. Contractors shall evaluate the circumstances surrounding the error and proceed with the appropriate plan of correction. See IOM Pub. 100-08, chapter 3, §3.1.

1.2.2 - MR Manager

(Rev.174, Issued: 11-17-06, Effective: 10-01-06, Implementation: 10-06-06)

An effective *MR program* begins with the strategies developed and implemented by senior management staff. Contractors must name *an* MR point of contact referred to as the MR manager *who* will act as the primary contact between the contractor and CMS concerning the contractor's *MR program.* The MR Manager will also have primary responsibility for the development, oversight and implementation of the contractor's *MR Strategy*, *Quarterly Strategy Analysis* (QSA) and quality assurance process. In addition, the MR Manager shall have the primary responsibility for ensuring the timely submission of the *MR strategy* and QSA.For the PSC, the MR manager shall be designated as key personnel in the PSC SOW.

1.2.3 - Annual *MR* Strategy

(Rev.174, Issued: 11-17-06, Effective: 10-01-06, Implementation: 10-06-06)

Each fiscal year, the contractors shall develop and document a unique annual *MR Strategy* within their jurisdiction. This strategy must be consistent with the goal of reducing the claims payment error rate.

The *MR strategy* shall detail identified MR *issues, activities*, projected goals, and the evaluation *of activities* and goals. It must be a fluid document that is revised, as targeted issues are successfully resolved, and other issues take their place. The initial strategy submitted at the beginning of the fiscal year shall be based on the strategy from the current fiscal year and updated and expanded upon as necessary.

The contractor shall analyze data from a variety of sources in the initial step in updating the *MR strategy*. The contractor shall use their CERT findings as the primary source of data to base further data analysis in identifying program vulnerabilities. Other data sources can include, but are not limited to, information gathered from other operational areas, such as appeals and inquiries, that interact with MR and *POE*.

After information and data is gathered and analyzed, the contractor shall develop and prioritize a problem list. A problem list is a list of the program vulnerabilities that threaten the Medicare Trust Fund that can be addressed through *MR activities*. The contractor shall consider resources and the scope of each identified medical review issue, when prioritizing their problem list. In addition, the contractor shall identify and address, in the problem list, work that is currently being performed and problems that will carry over to the following fiscal year. Once a problem list is created, the contractor shall develop *MR interventions* using the PCA process (IOM Pub 100-8, chapter 3, section 14) to address each problem.

The methods and resources used for *MR interventions* depend on the scope and severity of the problems identified and the *action* needed to successfully address the problems. For example, *if initial MR actions such as an MR notification letter to the provider and placement on prepayment review are insufficient to improve the provider's billing accuracy, a priority referral to POE for potential intervention may be necessary.*

Alternately, if on initial probe, a medium or high priority problem is identified, MR may determine that the initial issuance of probe result letter is insufficient, and a priority referral to POE, and/or more intensive medical review corrective actions may be required. A priority referral is an indication to the POE department that this is a problem which MR has determined will likely require further educational intervention. If, through communication with POE, it is determined that MR intervention and POE educational efforts have not effectively resolved the problem, a referral to the PSC BI unit may be indicated.

In addition, all claims reviewed by medical review shall be identified by MR data analysis and addressed as a prioritized problem in the *MR strategy* and reflected in the QSA. If resources allow, an MR nurse may be shared with another functional area, such as claims processing, as long as only the percentage of the nurses time spent on MR activities is identified in the strategy and accounted for in the appropriate functional area. For example, if MR agrees to share 0.5 of an FTE with claims processing to assist with the pricing of NOC claims, this 0.5 FTE shall be accounted for in claims processing.

The contractor shall develop multiple tools to effectively address *identified problems for the local Medicare providers*. The *MR strategy* shall include achievable goals and evaluation methods that test the effectiveness and efficiency *of activities* designed to resolve targeted medical review problems. *These evaluation methods will be dependent upon effective communication between the MR and POE departments. MR shall work with POE to develop an effective system of communication regarding the disposition of problems referred to POE. Within MR, a system shall be used to track referrals to POE, follow-up communication with POE, and MR interventions used to address identified problems. The PSC shall include logistics of referrals to POE within the AC or MAC in the JOA.*

As problems are addressed *within MR or referred to POE, the MR department* shall incorporate processes for follow-up that ensure appropriate resolution of the issue. If aberrancies continue, the contractor shall use the information *gathered through communication with POE* to determine a more progressive course of action*, such as increase in prepay MR, priority referral to POE, or referral to BI in cases of suspected fraud. Effective tracking of MR and POE efforts to resolve identified problems is integral to development of any case referred for potential investigation by the PSC (See PIM chapter 4, section 4.3).* As issues are successfully resolved, the contractor shall continue to address other program vulnerabilities identified on the problem list.

The *MR strategy* shall include a section that describes the process used to monitor spending in each CAFM II Activity Code. The process shall ensure that spending is consistent with the allocated budget and include a process to revise or amend the plan when spending is over or under the budget allocation. In addition, the strategy shall describe how workload for each CAFM II Activity Code is accurately and consistently reported. The workload reporting process shall also assure the proper allocation of employee hours required for each activity. Program safeguard contractors (PSC) shall not

report cost and workload using the CAFM II system. Instead, the contractor shall report cost and workload in the *CMS analysis, reporting, and tracking* (ART) system.

In each element of the *MR strategy*, the contractor shall incorporate quality assurance activities as described below. Quality assurance activities ensure that each element is being performed consistently and accurately throughout the contractor's MR program. In addition, the contractor shall have in place procedures for continuous quality improvement. Quality Improvement builds on quality assurance in that it allows the contractor to analyze the outcomes from their program and continually improve the effectiveness of their processes.

In order to assist contractors in developing their strategies, the CMS has developed the following generic template that can be used to help guide contractor planning and ensure that all activities and expected outcomes are reported. *Examples of actions which might be listed in the intervention list include, but are not limited to service-specific probes, notification letters, POE priority referrals, and automated denials based on LCDs***.**

Figure 1

FY 200_ Medicare Medical *Review Strategy*

Contractor Name:
Contractor Number:
Contractor MR site location(s):

Data Analysis Plan:
Prioritized Problems: **(1)**
(2)
(3)
Intervention Plan: **(1)**
(2)
(3)
Follow up Plan: **(1)**
(2)
(3)
Program Management:

- **Workload management process**
- **Cost allocation management process**
- **Staffing & Resource management process**
- **CMS Mandates**
- **PSC support**

Budget and Workload Chart:

Staffing Chart:

The contractor shall include the following elements in the *MR* strategy:

1.2.3.1 - Data Analysis and Information Gathering

(Rev.174, Issued: 11-17-06, Effective: 10-01-06, Implementation: 10-06-06)

The Data Analysis Plan shall list the data resources used in developing the strategy and the *MR process*. Examples of helpful resources include national database reporting systems, internal claims reports, provider feedback, team meetings with appeals and provider inquiry, SADMERC data, provider tracking tools to identify potential coverage and coding problems, CERT data, SAS 70 findings, Benefit Integrity (BI) information, and any additional data developed by the contractor. The *data analysis plan shall list the data resources and processes used in development of the MR strategy.*

Quality Assurance:

For quality assurances purposes, the contractor shall develop a process that includes frequent review of data and how the information is used. For example, establish a committee that routinely reviews data results. Document committee members' job titles, qualifications and contract operational areas they represent. Describe the log system or tracking system utilized for data analysis and how this information was developed via meetings and/or brainstorming. The contractor can use the CERT findings to demonstrate how well the contractor is performing their data analysis.

1.2.3.2 - Problem Identification & Prioritization

(Rev.174, Issued: 11-17-06, Effective: 10-01-06, Implementation: 10-06-06)

List all the problems identified and prioritize them. The contractor shall describe the method and criteria used to prioritize the problem list. The contractor should consider using scope of problem and resources available as criteria to prioritize the list. The list should be long while the *MR strategy* may only address the first few initially. When developing their prioritized list, the contractor shall consider their resources and other operational areas of the contractor with similar goals. The *MR strategy* is a fluid document and shall be continuously reviewed and adjusted as problems are resolved and new problems take are addressed.

Quality Assurance:

The contractor shall list the data and the metrics used to determine and verify each identified problem. That is, each identified problem should have an explanation of data and other information used to support the decision to include the problem and assign its priority. In addition, the quality assurance process shall ensure that *MR is* not focusing on problems that are being addressed by the Provider Outreach and Education (POE) unit or consistently being overturned on appeal. Furthermore, an effective quality assurance process shall include periodic meetings with other operational areas, including POE.

1.2.3.3 - Intervention Planning

(Rev.174, Issued: 11-17-06, Effective: 10-01-06, Implementation: 10-06-06)

To address the problems identified in the *MR strategy*, the contractor shall design a comprehensive plan of interventions. *Interventions* may involve projected medical review of claims, *referral of providers to POE or the PSC BI unit,* edit modifications and development or revisions of LCDs.

Quality Assurance:

The contractor shall include a quality assurance element in each intervention that checks for effectiveness and progress towards the specified goal. The QA component shall include a projected goal, a timeline to achieve the goal, and an element to assess effectiveness of the intervention and progress towards the stated goal. Examples of QA for interventions include, but are not limited to, tests for edit effectiveness, post-test of educational interventions, claims review after an educational intervention, systematic reviews of LCDs, etc. Finally, the QA component shall include a determination of whether the problem has been resolved or a more progressive course of action is required.

1.2.3.4 - Program Management

(Rev.174, Issued: 11-17-06, Effective: 10-01-06, Implementation: 10-06-06)

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

Quality Assurance:

The contractor shall describe in detail the Quality Improvement Process. Include the processes employed to assure accuracy and consistency in the reporting of spending, workload and staffing levels. The contractor shall address how to maintain accuracy in decision-making (inter-reviewer reliability) and response to provider inquiries. In addition, the contractor shall describe *the* system for *the* review and evaluation of the *MR* strategy.

1.2.3.5 - Budget and Workload Management

(Rev.174, Issued: 11-17-06, Effective: 10-01-06, Implementation: 10-06-06)

In order to effectively determine appropriate budget levels and accurately predict workload, the contractor shall complete the following chart (omitting the shaded areas) for each strategy developed. Note that this chart is only for the purposes of developing *an MR* strategy. Contractors are expected to report workloads and costs associated with all CAFM II activity codes and assigned workloads. Program safeguard contractors

(PSCs) shall not report cost and workload using the CAFM II system. Instead, the *PSC* shall report cost and workload in the *CMS* ART system.

ACTIVITY CODE	ACTIVITY	BUDGET	PROJECTED WORKLOAD		
			Workload 1	Workload 2	Workload 3
MEDICAL REVIEW PROGRAM					
21001	Automated Review				
21002	Routine Reviews				
21007	Data Analysis				
21206	Policy Reconsideration/Revision				
21207	*MR Program Management*				
21208	New Policy Development				
21220	Complex Probe Sample Review				
21221	Prepay Complex Manual Review				
21221/01	Reporting for Advanced Determinations of Medicare Coverage (ADMC)				
21222	Postpay Complex Review				
21901	MIP CERT Support				

NOTE: When submitting the Interim Expenditure Report (IER), all defined workloads shall be entered.

In addition:

- The contractor shall explain methods for determining the appropriate amount of review for each CAFM II Activity Code. Contractors may perform automated, routine, and complex prepayment review and post-payment reviews. Contractors shall determine the appropriate amount of review to be performed for each CAFM II code within the constraints of their budget. Consideration shall be given to the cost effectiveness of each tool, as well as the appropriateness of each tool for resolving identified problems in achieving the overall goal of reducing the claims payment error rate.

– The contractor shall automate as much review as possible. For those types of review that cannot be automated, the contractor shall be able to justify why they cannot be automated. Only in those instances where reviews cannot be automated and does not require clinical judgment shall the contractor conduct routine reviews.

– The contractor shall identify any support services that will be provided to a PSC. The strategy shall detail the role of the PSC in the overall *MR program* for the contractor. For the PSCs that perform some medical review functions, they shall be involved with the development of the *MR* strategy.

- The contractor shall identify the process for determining when the contractor will develop or revise LCD.

1.2.3.6 - Staffing and Workforce Management

(Rev.174, Issued: 11-17-06, Effective: 10-01-06, Implementation: 10-06-06)

Contractors shall complete and include the following chart to project the number of full-time-equivalent (FTE) employees, their job titles and qualifications.

CAFM II Code	FTE	Description & Qualifications
21001		
21002		
21007		
21010		
21206		
21207		
21208		
21220		
21221		
21221/01 (DMERCs only)		
21222		

The contractor shall submit a *MR* Strategy with their budget request to the appropriate RO and to CO at MRStrategies@cms.hhs.gov each fiscal year. The subject line of the e-mail shall begin with the contractor name followed by "Strategy" with the identifying fiscal year. The *MR* Strategy shall be updated as required. When an updated *MR* Strategy requires a SBR, the updated *MR* Strategy shall be sent with the SBR to the RO and to CO at MRStrategies@cms.hhs.gov. The PSC shall submit strategies with their draft project plan and final project plan, and update as required.

1.4 - *Contractor Medical Director (CMD)*

(Rev.174, Issued: 11-17-06, Effective: 10-01-06, Implementation: 10-06-06)

Contractors *who perform Medical Review* must employ a minimum of one FTE contractor medical director (CMD) and arrange for an alternate when the CMD is unavailable for extended periods. Waivers for very small contractors may be approved by the CO. The CMD FTE must be composed of either a Doctor of Medicine or a Doctor of Osteopathy. All clinicians employed or retained as consultants must be currently licensed to practice medicine in the United States, and the contractor must periodically verify that the license is current. When recruiting CMDs, contractors must give preference to physicians who have patient care experience and are actively involved in the practice of medicine. The CMD's duties are listed below.

Primary duties include:

- Leadership in the provider community, including:
    - Interacting with medical societies and peer groups;
    - Educating providers, individually or as a group, regarding identified problems or *LCDs*; and
    - Acting as co-chair of the carrier advisory committee (CAC) (see PIM chapter 13 §13.7.1.4 for co-chair responsibilities).
- Providing the clinical expertise and judgment to develop *LCDs* and internal MR guidelines:
    - Serving as a readily available source of medical information to provide guidance in questionable claims review situations;
    - Determining when *LCDs* are needed or must be revised to address program abuse;
    - Assuring that *LCDs* and associated internal guidelines are appropriate;
    - Briefing and directing personnel on the correct application of policy during claim adjudication, including through written internal claim review guidelines;
    - Selecting consultants licensed in the pertinent fields of medicine for expert input into the development of *LCDs* and internal guidelines;
    - Keeping abreast of medical practice and technology changes that may result in improper billing or program abuse;
    - Providing the clinical expertise and judgment to effectively focus MR on areas of potential fraud and abuse; and
    - Serving as a readily available source of medical information to provide guidance in questionable situations.

Other duties include:

- Interacting with the CMDs at other contractors to share information on potential problem areas;

- Participating in CMD clinical workgroups, as appropriate; and

- Upon request, providing input to CO on national coverage and payment policy, including recommendations for relative value unit (RVU) assignments.

To prevent conflict of interest issues, the CMD must provide written notification to CO (MROperations @cms.hhs.gov) and RO (for PSCs, the GTL, *Associate* GTL, and SME), as well as to the CAC, within 3 months after the appointment, election, or membership effective date if the CMD becomes a committee member or is appointed or elected as an officer in any State or national medical societies or other professional organizations. In addition, CMDs who are currently in practice should notify their RO (for PSCs, the GTL, Co-GTL, and SME) of the type and extent of the practice.

1.5 - *Maintaining the Confidentiality of MR Records*

(Rev.174, Issued: 11-17-06, Effective: 10-01-06, Implementation: 10-06-06)

Contractors must maintain the confidentiality of all MR records before, during, and after the MR process. Similarly, contractors that use a subcontractor(s) to perform MR, to store MR records, and/or to transport MR records, are responsible for ensuring that the subcontractor(s) maintains the confidentiality of the MR records that it handles. This responsibility applies to all contact with these records by all parties and entities, however derived from the contractor. The responsibility is not limited or ended if the subcontractor allows an additional party or entity to have contact with these records. Thus, just as the contractor must assure that the subcontractor maintain confidentiality itself, so too must the contractor assure that the subcontractor similarly assures that any third party or other entity, such as a sub to the subcontractor, which has contact with the records, maintain confidentiality.

Medicare Program Integrity Manual

Chapter 3 - Verifying Potential Errors and Taking Corrective Actions

Table of Contents
(Rev.174, 11-17-06)

3.1 – Introduction

(Rev.174, Issued: 11-17-06, Effective: 10-01-06, Implementation: 10-06-06)

Contractors must analyze provider compliance with Medicare coverage and coding rules and take appropriate corrective action when providers are found to be non-compliant. MR staff should not expend resources analyzing provider compliance with other Medicare rules (such as claims processing rules, conditions of participation, etc.). If during a review it is determined that a provider does not comply with conditions of participation, do not deny payment solely for this reason. Refer to the applicable state survey agency. The overall goal of taking administrative action should be to correct the behavior in need of change, to collect overpayments once identified, and deny payment when payment should not be made. For repeated infractions, or infractions showing potential fraud or pattern of abuse, more severe administrative action should be initiated. In every instance, the contractor's priority is to minimize the potential or actual loss to the Medicare Trust Funds while using resources efficiently and treating providers and beneficiaries fairly.

Contractor medical review (MR) staff shall coordinate and communicate with their associated *PSCs'* BI units to ensure coordination of efforts and to prevent inappropriate duplication of review activities.

A variety of interventions may be necessary in order to correct inappropriate behaviors. Contractors should use feedback and/or education as part of their intervention. Contractors should make sure that administrative actions are commensurate with the seriousness of the problem identified, after a limited probe is done to understand the nature and extent of the problem. Serious problems should be dealt with using the most substantial administrative actions available, such as 100 percent prepayment review, payment suspension, and use of statistical sampling for overpayment estimation of claims. Small and isolated problems should be dealt with through *provider notification or* feedback and reevaluation after *notification*. *When MR notification and feedback letters are issued, the contractor shall ensure that POE staff have ready access to copies of the letters so that POE staff will have this information available should a provider contact POE requesting education.* At any time, evidence of fraud should result in referral to the *PSC* BI *unit* for development.

3.1.1 – Provider Tracking System (PTS)

(Rev.174, Issued: 11-17-06, Effective: 10-01-06, Implementation: 10-06-06)

Medicare contractors must have in place a PTS. The PTS will identify all individual providers and track all contacts made as a result of actions to correct identified problems such as eligibility and medical necessity issues and repeated billing abusers who frequently change the way they code their bills to their financial advantage. *Contractors* should use the PTS to coordinate contacts with providers (e.g., MR *notifications, telephone calls directly related to probe or complex reviews, and referrals to provider outreach and education (POE)). contractors* should ensure that if a provider is to be contacted as a result of more than one problem, multiple contacts are necessary, timely

and appropriate, not redundant. *Contractors* should also coordinate this information with the PSC BI unit to assure contacts are not in conflict with benefit integrity related activities. The PTS should contain the date a provider is put on a provider specific edit. The *contractor* should reassess all providers on MR quarterly to determine whether the behavior has changed. The *contractor* must note the results of the quarterly assessment in the PTS. If the behavior has resolved sufficiently and the edit was turned off, note the date the edit was turned off in the PTS. When a provider appeals a medical review determination to an Administrative Law Judge (ALJ), the information in the PTS should be shared with the ALJ to demonstrate corrective actions have been taken by the *contractor*.

3.1.2 – Evaluating Effectiveness of Corrective Actions

(Rev.174, Issued: 11-17-06, Effective: 10-01-06, Implementation: 10-06-06)

Contractors who perform MR must evaluate the effectiveness of their corrective actions on targeted problem areas at least every 3 months until there is evidence that the problem is corrected. *Contractors shall establish a method to determine the disposition of educational referrals made to POE to ensure coordination of efforts and resolution of identified problems. Contractors may utilize the PTS to perform this function, but are not mandated to do so. Contractors* must use the PTS to coordinate contacts with providers *regarding MR activities. Contractors* must ensure that, if a provider is to be contacted as a result of more than one problem, multiple contacts *by MR* are necessary, timely and appropriate, not redundant. *Contractors* must also coordinate this information with their benefit integrity unit to assure contacts are not in conflict with fraud related activities.

3.2 – Verifying Potential Error and Setting Priorities

(Rev.174, Issued: 11-17-06, Effective: 10-01-06, Implementation: 10-06-06)

Understanding the characteristics of the service area of the provider is a key element of claim data analysis. The areas selected for review by the contractor (e.g., providers, services) must be deemed high priority and contractors must be able to document the rationale for selection. Using claims data, contractors shall determine the degree to which a potential error is widespread and decide if the potential error meets the deviation indicators established. When services and/or providers appear outside of norms, the contractor must verify that the potential error represents an unacceptable practice. Further investigate the provider(s) identified as causing the potential error.

Some examples of possible legitimate explanations for potential error are listed below. This is not an all-inclusive list.

- The provider may be associated with a medical school, research center, or may be a highly specialized facility; and
- The community may have special characteristics such as economic level or a concentration of a specific age group that leads to the aberrancy;

A. Error Validation Review

If no legitimate explanation exists for the potential error, the contractor should verify the cause of a potential error. The contractor shall not suspend large volumes of claims for review or use 100% prepayment review. Instead, the contractor shall select a sample of cases which is representative of the universe where the problem is occurring. The contractor shall request appropriate medical documentation and review cases for coverage and correct coding. MR staff should not be reviewing claims for compliance with other Medicare rules (i.e., claims processing, conditions of participation, etc.). Error validation reviews may be conducted on a prepayment or postpayment basis.

Where errors are verified, the contractor shall initiate appropriate corrective actions found in PIM, chapter 3, §§5, 6, 8, and 9.

Where no corrective action is taken, the contractor must document findings and explanations for not pursuing the problem. If no problems are found, the contractor shall discontinue the review. Do not wait until the end of the quarterly reporting period to end the review process.

In all situations where errors have been verified, the MR unit must notify the provider (written or verbal) that the particular practice or behavior is inappropriate and should not continue.

Error validation reviews require the examination of the provider's medical documentation but do not require use of statistical sampling for overpayment estimation methodologies. It does not allow projection of overpayments to the universe of claims reviewed. In this type of review, contractors collect overpayments only on claims that are actually reviewed, determined to be non-covered or incorrectly coded, and the provider is liable or at fault for the overpayment.

It may be used to determine:

- The extent of a problem across multiple providers, or
- Whether an individual provider has a problem.

Contractors shall select providers for Error Validation Reviews in, at a minimum, the following instances:

- The contractor has identified questionable billing practices, (i.e., noncovered or incorrectly coded services) through data analysis.
- Alerts from other intermediaries, carriers, QIOs, intermediary payment staff, or other internal components are received that warrant such review;
- Complaints.

Contractors must document their reasons for selecting the provider for the Error validation review. In all cases, they must clearly document the issues cited and the

applicable law or their published national coverage policies or *local coverage determinations, if applicable.*

3.2.1 – Determining Whether the Problem is Widespread or Provider Specific

(Rev.174, Issued: 11-17-06, Effective: 10-01-06, Implementation: 10-06-06)

For each verified priority problem, the contractor must determine whether the problem is widespread or provider specific. If the error is a widespread problem and evenly distributed among providers, contractors should validate the concern by following the instructions detailed in section 3.11.1.2 of this section. Take service-specific corrective actions:

- *Ensure POE has access to findings which may warrant widespread education,*
- Develop new/revised LCDs if needed, and
- Initiate service-specific prepay edits *where appropriate*.

If the error is limited to a small number of providers, contractors should validate the concern by following the instructions detailed in section 3.11.1.2 of this section.

3.2.2 - Administrative Relief from Medical Review in the Presence of a Disaster

(Rev.174, Issued: 11-17-06, Effective: 10-01-06, Implementation: 10-06-06)

When a disaster occurs, whether natural or man-made, contractors should anticipate both an increased demand for emergency and other health care services, and a corresponding disruption to normal health care service delivery systems and networks. In disaster situations, contractors should do whatever they can to assure that all Medicare beneficiaries have access to the emergency or urgent care they need. Contractors should let providers know (via website, responses to provider calls, etc.) that the provider's first responsibility, as in any emergency, is to provide the needed emergency or urgent service or treatment. Contractors should assure providers that they will work with providers to ensure that they receive payment for all covered services. The administrative flexibility available to contractors is discussed below. These actions will prevent most inappropriate denials and subsequent appeals.

A. Definition of Disaster

"Disaster" is defined as any natural or man-made catastrophe (such as hurricane, tornado, earthquake, volcanic eruption, mudslide, snowstorm, tsunami, terrorist attack, bombing, fire, flood, or explosion) which causes damage of sufficient severity and magnitude to:

1. Partially or completely destroy medical records and associated documentation that may be requested by the contractor in the course of a Medicare medical review audit,

2. Interrupt normal mail service (including US Postal delivery, overnight parcel delivery services etc.), or

3. Otherwise significantly limit the provider's daily operations.

A disaster may be widespread and impact multiple structures (e.g., a regional flood) or isolated and impact a single site only (e.g., water main failure). The fact that a provider is located in an area designated as a disaster by the Federal Emergency Management Act (FEMA) is not sufficient in itself to justify administrative relief, as not all structures in the disaster area may have been subject to the same amount of damage. Damage must be of sufficient severity and extent to compromise retrieval of medical documentation.

B. Basis for Providing Administrative Relief

In the event of a disaster, contractors may grant temporary administrative relief to any affected providers for up to 6 months *(or longer with good cause)*. Administrative relief is to be granted to these providers on a case-by-case basis in accord with the following guidelines:

- Contractors must make every effort to be responsive to providers who are victims of the disaster and whose medical record documentation may be partially or completely destroyed.

- Providers must maintain and, upon contractor request, submit verification that (1) a disaster has occurred and (2) medical record loss resulted from this disaster to the point where administrative relief from medical review requirements is necessary to allow the provider sufficient time to obtain *duplicates of lost records*, or reconstruct partially destroyed records.

Verification of the disaster and the resultant damage may include but is not limited to: (1) copies of claims filed by the provider with his/her insurance and liability company, (2) copies of police reports filed to report the damage, (3) copies of claims submitted to FEMA for financial assistance, (4) copies of tax reports filed to report the losses, or (5) photographs of damage. Contractors should not routinely request providers to submit verification of damage or loss of medical record documentation.

C. Types of Relief

<u>Providers Directly Impacted By Disaster</u>

When a provider who has been selected for complex pre or postpay review is directly affected by a disaster, the contractor should consider shifting the time period of the claims being reviewed to a later time period (e.g. 6 months later). Additional Documentation Requests (ADRs) should be *stopped* for providers who have been directly affected for at least *60* days. These claims should not be denied as noncovered and may

be tagged for later postpay review. Contractors should consult with their regional office prior to shifting the time period of review or suspend ADRs for certain providers.

Contractors should allow up to an additional 6 months beyond the original due date for the submission of requested records. Requests for extensions beyond this date may be granted with good cause at the discretion of the contractor.

In the case of complete destruction of medical records where backup records exist, contractors must accept reproduced medical record copies from microfiched, microfilmed, or optical disk systems that may be available in larger facilities, in lieu of the original document. In the case of complete destruction of medical records where no backup records exist, contractors must accept an attestation that no medical records exist and consider the services covered and correctly coded. In the case of partial destruction, contractors should instruct providers to reconstruct the records as best they can with whatever original records can be salvaged. Providers should note on the face sheet of the completely or partially reconstructed medical record: "This record was reconstructed because of disaster."

Providers Indirectly Impacted By Disaster

For providers that are indirectly affected by a disaster (e.g., an interruption of mail service caused by a grounding of US commercial air flights), contractors must take the following actions:

- For prepay or postpay documentation requests, extend the parameter that triggers denial for non-receipt of medical records from 45 days to 90 days. ADR letters must reflect that the response is due in 90 days rather than 45 days. This action will prevent most inappropriate denials and unnecessary increases in appeals workload.

- If a contractor receives the requested documentation after a denial has been issued but within a reasonable number of days beyond the denial date, the contractor should REOPEN the claim and make a medical review determination. Many contractors believe that 15 days is a reasonable number of days although contractors should make these decisions on a case-by-case basis. The workload, costs and savings associated with this activity should be allocated to the appropriate MR activity code (e.g., prepay complex or postpay complex review). Contractors should conduct these reopenings retroactively back to the date of the disaster.

D. Impact on Data Analysis

Contractors' data analysis should take into consideration the expected increase in certain services in disaster areas.

E. Impact on Contractor Performance Evaluation (CPE)

During CPE *and SAS-70* reviews, CMS will consider a waiver to all contractor MR requirements, as necessary, to allow contractors the flexibility where required to handle issues that arise in the presence of disaster. Examples of such requirements include workload targets and any other MR administrative rules. Contractors must retain documentation of how their MR operations were affected during the disaster and make it available to CPE *and SAS-70* review teams, CCMO staff, and local regional office staff, upon request.

3.3.- Articles

(Rev.174, Issued: 11-17-06, Effective: 10-01-06, Implementation: 10-06-06)

Contractors may publish articles communicating certain information to providers. *Articles may include any newly developed educational materials, coding instructions or clarification of existing medical review related billing or claims policy. Since 2003, contractors have been required to enter into the Medicare Coverage Database those articles that address local coverage, coding or medical review-related billing and claims considerations. Instructions for this requirement are in PM AB-02-098.*

For the purposes of this manual, the term "publish" will be used to describe any form of dissemination including posting on a Web site, distributing at a seminar, including an e-mailing, and printing in a hardcopy bulletin. *Medical review is responsible for the development of articles associated with new or revised LCDs, containing related coverage and coding information. MR is also responsible for the entering of those articles into the Medicare Coverage Database. Other widespread educational articles shall NOT be charged to MR.*

MR shall send articles to the appropriate department within the contractor for publishing. All newly created articles must be posted on the contractor's Web site where duplicate copies may be obtained by providers/suppliers.

When National Coverage Determinations (NCD) or other coverage instructions issued by CMS include specific conditions or parameters for which services may be covered, contractors may develop and publish a list of covered codes related to the coverage provision. Contractors may automate denials for codes not included on the list without the development of an *LCD* if the NCD indicates or states that no other condition or parameters will be covered.

- Contractors may publish definitions of procedure codes, lists of items that may be billed under a particular code, or minimum requirements that providers must meet in order to bill using a certain code.

- The contractor may publish a product classification list that instructs providers about which specific products meet the definitional requirements of a particular HCPCS code. Developing or revising an *LCD* for this article is unnecessary.

- The contractor may explain which off-labeled uses of FDA approved drugs are considered reasonable and necessary with the ICD-9-CM codes that reflect such uses.

The contractor may explain benefit category decisions and publish a list of drugs/biologicals that are considered usually self-administered.

On a flow basis, contractors shall report those injectable drugs that are excluded when furnished incident to a physician's service on the basis that the drug is usually self-administered by the patient. Contractors must enter their self-administered drug exclusion list into the Medicare Coverage Database. This database can be accessed at www.cms.hhs.gov/mcd.

In order to ensure that the Self-Administered Drug (SAD) Exclusion List report in the Medicare Coverage Database functions correctly, contractors must:

- Ensure that all CPT code information in a SAD exclusion article is listed in field 22.

- Ensure that all SAD exclusion articles are entered with the "SAD article" type. Contractors must not use the "General Detailed," "General Basic," or "FAQ" article types for their SAD exclusion articles.

- Ensure that the "End Date" for each drug listed in field 22 is correct. The end date should reflect the date that the drug is no longer excluded as self-administered.

- Review their SAD articles annually to ensure that the following requirements are met:

Drugs that have never been SAD-excluded	**Not on the list**
Drugs that were once SAD-excluded, but now are not SAD-excluded	Either: - On the list with an accurate "End Date," or - Were deleted from the list with an accurate article "Effective Date"
Drugs that are currently SAD-excluded	On the list

- The contractor may explain which HCPCS code or group of codes properly describes a particular service.

- The contractor may publish State non-physician licensure information that governs services billed by the physician under the "incident to" provision.

Articles may not conflict with NCDs or coverage provisions in interpretive manuals. Although a comment and notice process is not required, contractors are encouraged to consult with stakeholders in the provider community when developing articles.

Contractors must monitor comments about articles from clinician providers and respond to their concerns, as needed, by issuing revised or clarifying articles.

NOTE: Nothing in this section precludes the contractors from making individual claim determinations, even in the absence of an article or LMRP.

3.4 - Overview of Prepayment and Postpayment Review for MR Purposes

(Rev.174, Issued: 11-17-06, Effective: 10-01-06, Implementation: 10-06-06)

The instructions listed in this section (section 3.4) apply only to reviews conducted for MR purposes unless otherwise noted. When MR staff are performing BI-directed prepay or postpay claims review, the MR staff should seek direction from the BI staff. For example, if the provider calls the MR staff and requests feedback on the review results pursuant to the requirements for progressive corrective action, the MR staff should seek guidance from the BI unit.

When MR departments make referrals to POE, they shall maintain communication with POE regarding educational interventions completed and must continue to deny non-covered and incorrectly coded services even while provider education is occurring.

Prepayment MR of claims requires that a benefit category review, statutory exclusion review, reasonable and necessary review, and/or coding review be made BEFORE claim payment. Prepayment MR of claims always results in an "initial determination." See Pub. 100-04, chapter 29, section 30.3, for a complete definition of "initial determination."

Postpayment MR of claims requires that a benefit category review, statutory exclusion review, reasonable and necessary review, and/or coding review be made AFTER claim payment. These types of review allow the contractor the opportunity to make a determination to either pay a claim (in full or in part), deny payment or assess an overpayment. Postpayment MR of claims may result in no change to the initial determination or may result in a "revised determination." See 42 CFR 405.841 and 42 CFR 405.750 for a complete definition of "revised determination."

When initiating prepay or postpay review (provider specific or service-specific), contractors must notify providers of the following:

- That the provider has been selected for review and the specific reason for such selection. If the basis for selection is comparative data, contractors must provide comparative data on how the provider varies significantly from other providers in the same specialty payment area or locality. Graphic presentations may help to communicate the perceived problem more clearly;

- Whether the review will occur on a prepayment or postpayment basis;

- If postpayment, the list of claims that require medical records*; and*

- The OMB Paperwork Reduction Act collection number, which is 0938-0969. This number needs to be on every additional documentation request (ADR) or any other type of written request for additional documentation for medical review. It can be in the header, footer or body of the document. We suggest the information read "OMB #: 0938-0969" or "OMB Control #: 0938-0969."

This notice must be in writing and may be issued separately or in the same letter that lists the additional documentation that is being requested. Contractors may (but are not required to) make this notification via certified letter with return receipt requested. In addition, the contractor may include information on its Web site explaining that service-specific review will be occurring and the rationale for conducting such review.

3.4.1.2 - Additional Documentation Requests (ADR) During Prepayment or Postpayment MR

(Rev.174, Issued: 11-17-06, Effective: 10-01-06, Implementation: 10-06-06)

When contractors cannot make a coverage or coding determination based upon the information on the claim and its attachments, the contractors may solicit additional documentation from the provider by issuing an additional documentation request (ADR). Contractors must request records related to the claim(s) being reviewed. Contractors may collect documentation related to the patient's condition before and after a service in order to get a more complete picture of the patient's clinical condition. *The contractor may* not deny other claims related to the documentation of the patient's condition before and after the claim in question unless you review and give appropriate consideration to the actual additional claims and associated documentation.

Contractors must specify in the ADR the specific pieces of documentation needed (and ONLY those pieces needed) to make a coverage or coding determination.

When reviewing documentation during medical review, contractors shall review and give appropriate consideration to all documentation that is provided. Documentation provided for pre- or post-payment medical review must support the medical necessity of the item(s) or service(s) provided.

The treating physician or another clinician or provider may create this documentation. This documentation may take the form of PT/OT evaluations, physician letters, other written physician evaluations, or other documents intended to record relevant information about a patient's clinical condition and treatment(s).

The date that an individual document was created, or the creator of a document is not the sole deciding factor in determining if the documentation supports the services billed.

In instances where documentation is not supported by contemporaneous information in physician progress notes, physician progress notes shall be the determining factor. In

instances where documentation is provided in lieu of contemporaneous physician progress notes, contractors shall determine if the documentation is sufficient to justify coverage. If it is not, the claim shall be denied.

A. Development of Non-Lab Claims for Additional Documentation

If, during pre- or postpay review, a contractor chooses to send an Additional Documentation Request (ADR) regarding a non-lab targeted service, they must solicit the documentation from the billing provider and may solicit documentation from other entities (third parties) involved in the beneficiary's care. If a contractor chooses to solicit documentation from a third party, they may send the third party ADR simultaneously with the billing provider ADR. Contractors must send ADRs in accordance with the following requirements:

Billing Provider ADRs

- Contractors who choose to request additional documentation must solicit such information from the billing provider and must notify them that they have 30 days to respond. Contractors have the discretion to grant an extension of the timeframe upon request. The contractor must pend the claim for 45 days. Contractors may cc a third party.

- Contractors have the discretion to issue no more than 2 "reminder" notices via letter or phone call prior to the 45th day.

- If information is automatically requested only from the billing provider and no response is received within 45 days after the date of the request (or extension), the contractor must deny the service as not reasonable and necessary (except for ambulance claims where the denial may be based on §1861(s)(7) or §1862(a)(1)(A) of the Act depending upon the reason for the requested information). This would count as automated review.

- If information is requested only from the billing provider and the information received fails to support the coverage or coding of the claim, in full or in part, the contractor must deny the claim, in full or in part, using the appropriate denial code (see section 3.4.2). This would count as a complex review.

THIRD PARTY ADRs

A contractor may NOT solicit documentation from a third party unless the contractor first or simultaneously solicits the same information from the billing provider. Beneficiaries are not third parties.

When a contractor solicits documentation from a third party:

- The contractor must notify the third party that they have 30 days to respond and copy the billing provider. Contractors have the discretion to grant extensions of the timeframe upon request.

- For prepay review, the contractor must pend the claim for 45 days. This 45 day time period may run concurrent with the 45 day time period for the billing provider ADR letter;

- Contractors have the discretion to issue no more than 2 "reminder" notices via e-mail, letter or phone call prior to the 45th day;

- If information is requested from both the billing provider and a third party and no response is received from either within 45 days after the date of the request (or extension), the contractor must deny the claim, in full or in part, as not reasonable and necessary. This would count as automated review.

- If information requested from both the billing provider and a third party and a response is received from one or both, but the information fails to support the coverage or coding of the claim, the contractor must deny the claim, in full or in part, using appropriate denial code (see section 3.4.2).

B. Development of Lab Claims for Additional Documentation

Effective November 25, 2002, contractors shall develop lab claims in accordance with the following requirement:

- If, during pre- or postpay review, a contractor chooses to send an ADR regarding a targeted lab service, they must solicit the documentation from the billing provider, and under certain circumstances, must also solicit documentation from the ordering provider.

Contractors must send ADRs in accordance with the following requirements:

Billing Provider ADRs

- Contractors who choose to request additional documentation must solicit such information from the **billing provider** and must notify them that they have 30 days to respond. Contractors have the discretion to grant an extension of the time frame upon request. For prepay review, the contractor must pend the claim for 45 days. Contractors may solicit billing providers only for the following information:

    - Documentation of the order for the service billed (including information sufficient to allow the contractor to identify and contact the ordering provider);

    - Documentation showing accurate processing for the order and submission of the claim; and

    - Diagnostic or other medical information supplied to the billing provider by the ordering provider, including any ICD-9 codes or narratives supplied.

- Contractors have the discretion to issue no more than 2 "reminder" notices via letter, e-mail, or phone call prior to the 45th day;

- If no response is received from the billing provider within 45 days after the date of the request (or extension), the contractor must deny the service as not reasonable and necessary. This would count as automated review;

- If a response is received that demonstrates that the service is not covered or correctly coded, the contractor must deny. This would count as complex review;

- If the information requested from the billing provider is received, does not demonstrate noncoverage or incorrect coding of the claim, but fails to support the coverage or coding of the claim in full or in part, the contractor must:

    - Deny the claim if a benefit category, statutory exclusion, or coding issue is in question, or;

    - Develop to the ordering provider in accordance with the requirements listed below if a reasonable and necessary issue is in question.

Ordering Provider ADRs

A contractor may NOT solicit documentation from the ordering provider unless the contractor:

1. Solicits information from the billing provider,

2. Finds the ADR response from the billing provider insufficient or not provided, and

3. The issue in question is one of medical necessity. Contractors may implement these requirements to the extent possible without shared systems changes.

When a contractor solicits documentation from the ordering provider the contractor must provide to the ordering provider information sufficient to identify the claim being reviewed.

- The contractor must solicit from the ordering provider those parts of the medical record that are relevant to the specific claim(s) being reviewed. The contractor must notify the ordering provider that they have 30 days to respond and copy the billing provider. Contractors have the discretion to grant extensions of the time frame upon request.

- For prepay review, the contractor must pend the claim for 45 days.

- Contractors have the discretion to issue no more than 2 "reminder" notices via e-mail, letter or phone call prior to the 45th day.

- If information is requested from the ordering provider and no response is received deny the claim, in full or in part, as not reasonable and necessary. This would within 45 days after the date of the request (or extension), the contractor must count as automated review.

- If the information requested from the ordering provider is received, but the information fails to support the coverage or coding of the claim, the contractor must deny the claim, in full or in part, using appropriate denial code (see section 3.4.2). This would count as a complex review.

C. Psychotherapy Notes

Psychotherapy notes are defined in 45 CFR §164.501as “notes recorded by a mental health professional which document or analyze the contents of a counseling session and that are separated from the rest of a medical record.” The definition of psychotherapy notes expressly **excludes** medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, andany summary of diagnosis, functional status, treatment plan, symptoms, prognosis, progress, and progress to date. etc., and this class of information does not qualify as psychotherapy note material. Physically integrating information excluded from the definition of psychotherapy notes and protected information into one document or record does not transform the non-protected information into protected psychotherapy notes.

Under no circumstances shall a contractor request a provider to submit notes defined in 45 CFR §164.501. The refusal of a provider to submit such information shall not result in the denial of a claim.

If the medical record includes any of the information excluded from the definition of psychotherapy notes in §164.501, as stated above, the provider is responsible for extracting the information required to support that the claim is reasonable and necessary. Contractors must review the claim using all supporting documentation submitted by the provider. If the provider does not submit sufficient information to demonstrate that services were medically necessary, the claim will be denied.

3.4.2 – Denials Notices

(Rev.174, Issued: 11-17-06, Effective: 10-01-06, Implementation: 10-06-06)

Contractors must deny claims, in full or in part, under the circumstances listed below. Contractors do not have the option to "Return to Provider" or reject claims under these circumstances. Contractors must deny the claim in full or in part. See Ruling 95-1 for further information on partials denials (known as "down coding").

A. Denial Reasons Used for Reviews Conducted for MR or BI Purposes

Contractors must deny payment on claims either partially (e.g., by down coding, or denying one line item on a multi-line claim) or in full and provide the specific reason for the denial whenever there is evidence that a service:

- Does not meet the Benefit Category requirements described in Title XVIII of the Act and national coverage determination, coverage provision in interpretive manual, or LCD;

- Is statutorily excluded by other than §1862(a)(1) of the Act;

- Is not reasonable and necessary as defined under §1862(a)(1) of the Act. (Contractors shall use this denial reason for all non-responses to ADRs.); and

- Was not billed in compliance with the national and local coding requirements.

Contractors must give the specific reason for denial. Repeating one of the above bullets is not a specific reason.

B. Denial Reasons Used for Reviews Conducted for BI Purposes

Contractors must deny payment on claims either partially (e.g., by down coding or denying one line item on a multi-line claim) or in full whenever there is evidence that a service:

- Was not rendered (or was not rendered as billed);
- Was furnished in violation of the self referral prohibition; or
- Was furnished, ordered or prescribed on or after the effective date of exclusion by a provider excluded from the Medicare program and that provider does not meet the exceptions identified below in PIM chapter 4, §4.21.2.6.

Contractors must deny payment whenever there is evidence that an item or service was not furnished, or not furnished as billed even while developing the case for referral to OIG or if the case has been accepted by the OIG. In cases where there is apparent fraud, but the case has been refused by law enforcement, contractors deny the claim(s) and collect the overpayment where there is fraud- - after notifying law enforcement. It is necessary to document each denial thoroughly to sustain denials in the appeals process. Intermediaries must make adjustments in cost reports, as appropriate.

C. Denial Notices

If a claim is denied, in full or in part, the contractor must notify the beneficiary and/or the provider. The contractor shall include limitation of liability and appeals information. Notification can occur via Medicare Summary Notice (MSN) and Remittance Advice.

Beneficiary Notices

Contractors are required to give notice to Medicare beneficiaries when claims are denied in part or in whole based on application of *an LCD.* All denials that result *from LCDs* must provide the MSN message 15.19 in addition to the current applicable message. Message 15.19 states (Pub. 100-04, chapter 21):

> "A local medical review policy (LMRP) or local coverage determination (LCD) was used when we made this decision. An LMRP/LCD provides a guide to assist in determining whether a particular item or service is covered by Medicare. A copy of this policy is available from your local intermediary or carrier by calling the number in the customer service information box on page one. You can

compare the facts in your case to the guidelines set out in the LMRP/LCD to see whether additional information from your physician would change our decision."

You shall make these messages available in Spanish where appropriate. The 15.19 portion of the MSN message states:

> 15.19 - Una Política Local de Revisión Médica (LMRP, por sus siglas en inglés) o una Determinación de Cobertura Local (LCD, por sus siglas en inglés) fue utilizada cuando se tomó esta decisión. La Política Local de Revisión Médica y la Determinación de Cobertura Local proveen una guía que ayuda a determinar si un artículo o servicio en particular está cubierto por Medicare. Una copia de esta política está disponible en su intermediario o su empresa de seguros Medicare local al llamar al número que aparece en la sección de Servicios al Cliente en la página uno. Usted puede comparar los datos de su caso con las reglas establecidas en la Política Local de Revisión Médica y en la Determinación de Cobertura Local para ver si obteniendo información adicional de su médico pudiera cambiar nuestra decisión.

Use the above message in every instance of a prepayment denial where *an LCD* was used in reviewing the claim. Use this message, and message 15.20 (now for FISS FI's, and when 15.20 is fully implemented for contractors on the MCS/VMS systems) on both full and partial denials, whether the denial was made following automated, routine, or complex review. Do not use this message on denials not *involving LCDs*. For claims reviewed on a postpayment basis, use the above message if sending the beneficiary a new MSN. If sending a letter, include the language exactly as contained in the MSN message above.

Message 15.20 currently states "The following policies [*insert LCD* ID #(s) and NCD #(s)] were used when we made this decision."(Pub. 100-04, chapter 21). 15.19 must continue to be used in conjunction with the MSN message 15.20, where 15.19 is applicable. Contractors may combine these messages if necessary, but 15.19 must not be deleted.

Provider Notices

Prepay Denial Messages

Because the amount of space is limited, contractors need only provide high-level information to providers when informing them of a prepayment denial via a remittance advice. In other words, the shared standard system remittance advice messages are sufficient notices to the provider. However, for routine and complex review, the contractor must retain more detailed information in an accessible location so that upon written or verbal request from the provider, the contractor can explain the specific reason the service was considered non-covered or not correctly coded.

Post Pay Denial Messages

When notifying providers of the results of post pay medical review determinations, the contractor must explain the specific reason each service was considered non-covered or not correctly coded.

Indicate in the Denial Notice Whether Records Were Reviewed

Effective March 1, 2002, for claims where the contractor has sent an ADR letter and no timely response was received, contractors must make a §1862(a)(1) of the Act denial (except for ambulance claims where the denial may be based on §1861(s)(7) or §1862(a)(1)(A) of the Act depending upon the reason for the requested information) and indicate in the provider denial notice, using remittance advice code N102, that the denial was made without reviewing the medical record because the requested records were not received or were not received timely. This information will be useful to the provider in deciding whether to appeal the decision.

For claims where the contractor makes a denial following complex review, contractors may, at their discretion, indicate in the denial notice, using remittance advice code N109 that the denial was made after review of medical records. This includes those claims where the provider submits medical records at the time of claim submission and the contractor selects that claim for review.

D. Audit Trail

For reporting purposes, contractors need to differentiate automated, routine and complex prepayment review of claims. Contractor systems must maintain the outcome (e.g., audit trail) of prepayment decisions such as approved, denied, or partially denied. When downcoding, contractors must retain a record of the HCPCS codes and modifiers that appeared on the original claim as submitted.

E. Distinguishing Between Benefit Category, Statutory Exclusion and Reasonable and Necessary Denials

Contractors must be very careful in choosing which denial type to use since beneficiaries' liability varies based on denial type. Benefit category denials take precedence over statutory exclusion and reasonable and necessary denials. Statutory exclusion denials take precedence over reasonable and necessary denials. Contractors should use HCFA Ruling 95-1 and the guidelines listed below in selecting the appropriate denial reason.

- If the contractor requests additional documentation from the provider or other entity (in accordance with PIM chapter 3, section 4.1.2.) for any MR reason (benefit category, statutory exclusion, reasonable/necessary, or coding), and the information is not received within 45 days, the contractor should issue a reasonable and necessary denial, in full or in part.

- If the contractor requests additional documentation because compliance with a benefit category requirement is questioned and the contractor receives the additional

documentation, but the evidence of the benefit category requirement is missing, the contractor should issue a benefit category denial.

- If the contractor requests additional documentation because compliance with a benefit category requirement is questioned and the contractor receives the additional documentation, which shows evidence that, the benefit category requirement is present but is defective, the contractor should issue a reasonable and necessary denial.

EXAMPLE: A contractor is conducting a review of partial hospitalization (PH) services on a provider who has a problem with failing to comply with the benefit category requirement that there be a signed certification in the medical record. In the first medical record, the contractor finds that there is no signed certification present in the medical record. The contractor must deny all PH services for this beneficiary under §1835(a)(2)(F) of the Act (a benefit category denial). However, in the second medical record, the contractor determines that a signed certification is present in the medical record, but the documentation does not support the physician's certification, the services must be denied under §1862(a)(1)(A) of the Act (a reasonable and necessary denial) because the certification is present but defective.

- If a contractor performs routine review on a surgical procedure and determines that the procedure was cosmetic surgery and was not reasonable and necessary, the denial reason would be that the service is statutorily excluded since statutory exclusion denials take precedence over reasonable and necessary denials.

3.4.4 - Internal MR Guidelines

(Rev.174, Issued: 11-17-06, Effective: 10-01-06, Implementation: 10-06-06)

As part of its process of reviewing claims, contractor MR staff may develop detailed written review guidelines ("Internal MR Guidelines.") Internal MR Guidelines, in essence, will allow the contractor to *operationalize LCDs* and NCDs. Internal MR Guidelines shall specify what information should be reviewed by routine reviewers and the appropriate resulting determination. Contractor MR staff must make their Internal MR Guidelines available to their internal staff (e.g. *POE,* the appeals unit, etc.), PSC, or BI unit, as needed. Internal MR Guidelines must not create or change policy.

3.4.5 - Types of Prepayment and Postpayment Review

(Rev.174, Issued: 11-17-06, Effective: 10-01-06, Implementation: 10-06-06)

Claim review activities are divided into three distinct types of review:

A. Automated Prepayment Review

When prepayment review is automated, decisions are made at the system level, using available electronic information, without the intervention of contractor personnel. See Section 5.1 for further discussion of automated prepayment review.

B. Routine Prepayment/Postpayment Review

Routine prepayment review is limited to rule-based determinations performed by specially trained MR staff. An intervention can occur at any point in the review process. For example, a claim may be suspended for routine review because an MR determination cannot be automated.

Routine review requires hands-on review of the claim, and/or claims history file and/or internal MR guidelines but does not require the application of clinical judgment by a licensed medical professional.

C. Complex Prepayment/Postpayment Review

Complex medical review involves the application of clinical judgment by a licensed medical professional in order to evaluate medical records. Medical records include any medical documentation, other than what is included on the face of the claim that supports the service that is billed. For items of durable medical equipment that require a Certificate of Medical Necessity (CMN), the CMN is considered part of the face of the claim. Complex medical review determinations require a licensed medical professional to make a clinical judgment about whether a service is covered, and is reasonable and necessary.

Complex review for the purpose of making coverage determinations must be performed by nurses (RN/LPN) or physicians, unless this task is delegated to other licensed health care professionals. Contractors must ensure that services reviewed by other licensed health care professionals are within their scope of practice and that their *MR Strategy* supports the need for their specialized expertise in the adjudication of particular claim type (i.e. speech therapy claim, physical therapy claim). Contractors should establish QI processes that verify the accuracy of MR decisions made by licensed health care professionals.

Contractors must maintain a credentials file for each reviewer who performs one or more complex reviews (including consultants, contract staff, subcontractors, and temporary MR staff). The credentials file must contain at least a copy of the reviewer's professional license.

During complex review, nurse and physician reviewers may call upon other health care professionals (e.g., dieticians, and physician specialists) for advice. Any determination must be documented and include the rationale for the decision. While MR staff must follow National Coverage Determinations and Local Coverage Determinations, they are expected to use their expertise to make clinical judgments when making medical review determinations. They must take into consideration the clinical condition of the beneficiary as indicated by the beneficiary's diagnosis and medical history when making these determinations. For example, if a medical record indicates that a beneficiary is a few days post-op for a total hip replacement and femur plating, even though the medical record does not specifically state that the beneficiary requires the special skills of

ambulance transportation, MR nurses and physicians must use their clinical knowledge to conclude that ambulance transportation is appropriate under such circumstances. Complex medical review performed by medical review staff for purposes other than MR (for example, for benefit integrity investigations or for appeals) should be charged for expenditure reporting purposes to the area requiring medical review services.

D. Examples

The following examples are provided to assist contractors in understanding the definitions of automated, routine, and complex review.

EXAMPLE 1: A contractor sets up the system so that for a particular HCPCS/ICD9 combination, the computer will request documentation, suspend for manual review, and auto-deny in 45 days if no documentation is received. For claims where no documentation is received within 45 days, the computer auto-denies the claim without manual intervention. Even though the contractor intended to perform manual review, because they ACTUALLY performed automated review, this review should be counted a AUTOMATED.

EXAMPLE 2:A contractor sets up the system so that for a particular HCPCS/ICD9 combination, the computer will suspend for routine review. During routine manual review, the reviewer determines that complex review is needed and initiates a request for additional documentation. For claims where no documentation is received within 45 days, the computer denies the claim. Because the contractor ACTUALLY performed routine manual review, this claim should be counted as ROUTINE review.

EXAMPLE 3:A contractor sets up the system so that for a particular HCPCS/ICD9 combination, the computer will suspend for routine manual review. During routine manual review, the reviewer determines that complex review is needed and initiates a request for additional documentation. For claims where documentation is received, MR nurses (RN/LPN) or physicians will review the documentation and make a decision regarding the services billed. Because the HIGHEST LEVEL of review the contractor performed was complex manual review, this claim should be counted as COMPLEX review.

3.4.6 -Spreading Workload Evenly

(Rev.174, Issued: 11-17-06, Effective: 10-01-06, Implementation: 10-06-06)

The type and amount of workload a contractor must perform each year is specified in their MR strategy or Statement of Work (SOW).

3.5.1.1 - Prepayment Edits

(Rev.174, Issued: 11-17-06, Effective: 10-01-06, Implementation: 10-06-06)

Prepayment edits are designed by contractor staff and put in place to prevent payment for non-covered and/or incorrectly coded services and to select targeted claims for review prior to payment. Medical review (MR) edit development is the creation of logic (the edit) that is used during claims processing prior to payment that validates and/or compares data elements on the claim.

Contractors may not install edits that result in the automatic denial of services based solely on the diagnosis of a progressively debilitating disease where treatment may be reasonable and necessary. The appearance of a progressively debilitating disease on a claim or history does not permit automated prepay denials that presume a stage of that disease that negates the effectiveness of treatment. Additionally, when a beneficiary with a progressively debilitating disease experiences an illness or injury unrelated to their progressively debilitating disease, the provider should submit a claim with a primary diagnosis that most accurately reflects the need for the provided service. For example, following a hip replacement in a patient with Alzheimer's Disease, a physical therapy provider should submit a claim using ICD-9 Code V54.81 (aftercare following joint replacement) as the primary diagnosis, not ICD-9 Code 331.0 (Alzheimer's Disease). Automated denials may only be used when the service, in that circumstance, is never reasonable and necessary. For example, an electromyography (EMG) for Alzheimer's may be auto denied because it will never be reasonable and necessary for that ICD code; but EMG may not be auto denied when the claim shows "focal muscular weakness" -- even though that claim also shows Alzheimer's. Physical therapy may not be auto denied solely because multiple sclerosis appears on the claim, but may be if there is no other justification for the service listed. There are stages of the disease at which, for example, physical therapy for gait training will not be effective, but MR must look into the claims history or examine records to make that determination**.**

A. Ability to Target

Contractors must focus edits to suspend only claims with a high probability of being denied on MR. Focused edits reduce provider burdens and increases the efficiency of MR activities. Edits should be specific enough to identify only the services that the contractor determines to be questionable based on data analysis. Prepayment edits must be able to key on a beneficiary's Health Insurance Claim Number (HICN), a provider's identification (e.g., Provider Identification Number (PIN), UPIN) and specialty, service dates, and medical code(s) (i.e., HCPCS and/or ICD-9 diagnoses codes). Intermediary edits must also key on Type of Bill (TOB), revenue codes, occurrence codes, condition codes, and value codes.

Medicare fiscal intermediary and carrier systems must be able to select claims for prepayment review using different types of comparisons. At a minimum, those comparisons must include:

- Procedure-to-Procedure – This relationship permits contractor systems to screen multiple services at the claim level and in history.

- Procedure to Provider – For a given provider, this permits selective screening of services that need review.

- Frequency to Time – This allows contractors to screen for a certain number of services provided within a given time period.

- Diagnosis to Procedure – This allows contractors to screen for services submitted with a specific diagnosis. For example, the need for a vitamin Bl2 injection is related to pernicious anemia, absence of the stomach, or distal ileum. Contractors must be able to establish edits where specific diagnosis/procedure relationships are considered in order to qualify the claim for payment.

- Procedure to Specialty Code (Carrier) or TOB (FI) – This permits contractors to screen services provided by a certain specialty or TOB.

- Procedure to Place of Service – This allows selective screening of claims where the service was provided in a certain setting such as a comprehensive outpatient rehabilitation facility.

Additional intermediary edits include, but are not limited to, the following:

- Diagnoses alone or in combination with related factors, e.g., all ICD-9-CM codes XXX.X-XXX.X with revenue code (REV) XXX and units greater than X;

- Revenue and/or HCPCS codes, e.g., a REV with a selected HCPCS (REV XXX with HCPCS XXXXX);

- Charges related to utilization, e.g., an established dollar limit for specific REV or HCPCS (REV XXX with HCPCS XXXXX with charges over $500);

- Length of stay or number of visits, e.g., a selected service or a group of services occurring during a designated time period (bill type XXX with covered days/visits exceeding XX); and

- Specific providers alone or in combination with other parameters (provider XX-XXXX with charges for REV XXX).

B. Evaluation of Prepayment Edits

Development or retention of edits should be based on data analysis, identification, and prioritization of identified problems. The contractor must evaluate all service specific and provider specific prepayment edits as follows:

- Automated edits must be evaluated annually.

- All routine or complex review edits must be evaluated quarterly.

These evaluations are to determine their effectiveness and contribution to workload. Contractors shall consider an edit to be effective when an edit has a reasonable rate of denial relative to suspensions and a reasonable dollar return on cost of operation or potential to avoid significant risk to beneficiaries. Revise or replace edits that are ineffective. Edits may be ineffective when payments or claims denied are very small in proportion to the volume of claims suspended for review. It is appropriate to leave edits in place if sufficient data are not available to evaluate effectiveness, if a measurable impact is expected, or if a quarter is too brief a time to observe a change. Contractors should analyze prepayment edits in conjunction with data analysis to confirm or re-establish priorities. Contractors should replace, if appropriate, existing effective edits to address problems that are potentially more costly.

FACTORS CONTRACTORS MUST CONSIDER IN LOOKING AT EDIT EFFECTIVENESS FOR **ESTABLISHED AUTOMATED** EDITS:

- Time and staff needed for review, including appeals reviews. Contractors must implement mechanisms (e.g., manual logs, automated tracking systems) to allow the appeals unit to communicate to the MR unit information such as which denial categories are causing the greatest impact on appeals, the outcome of the appeal) Contractors must maintain and make available to the RO (for (PSCs, the Primary GTL, Associate GTL, and SME) and central office (CO) staff documentation demonstrating that they consider appeals in their edit evaluation process; and

- Specificity of edits in relation to identified problem(s).

- Contractors should note that even an automated edit that results in no denials may be effective so long as the presence of the edit is not preventing the installation of other automated edits.

FACTORS CONTRACTORS MUST CONSIDER IN LOOKING AT EDIT EFFECTIVENESS FOR **ALL OTHER** EDITS:

- Time and staff needed for review, including appeals reviews. Contractors must implement mechanisms (e.g., manual logs, automated tracking systems) to allow the appeals unit to communicate to the MR unit information such as which denial categories are causing the greatest impact on appeals, the outcome of the appeal. Contractors must maintain and make available to RO and CO staff documentation demonstrating that they consider appeals in their edit evaluation process.

- Specificity of edits in relation to identified problem(s);

- Demonstrated change in provider behavior, e.g., the contractor can show the decrease in frequency of services per beneficiary, the decrease in the number of

beneficiaries receiving the services, the service is no longer billed, or another valid measure can be used to reflect a change in provider behavior over time;

- Impact of educational or deterrent effect in relation to review costs; and

- The presence of more costly problems identified in data analysis that needs higher priority than existing edits considering the number of claims/days/charges reviewed in comparison to claims/days/charges denied.

Contractors must test each edit before implementation and determine the impact on workload and whether the edit accomplishes the objective of efficiently selecting claims for review.

C. Adding Local Medical Review Policy (LMRP)/Local Coverage Determination (LCD) and National Coverage Determination (NCD) ID Numbers to Edits

The FIs must ensure that any edit that may result in a denial based on an LMRP/LCD or NCD includes the LMRP/LCD or NCD ID number(s) associated with the denial.

The FIs must ensure that any edit that may result in a denial based on a lab negotiated NCD includes the NCD ID number(s) associated with the denial.

The VMS carriers and PSCs must ensure the analysis and design is completed for any edit that may result in a denial based on an LMRP/LCD or NCD includes the LMRP/LCD ID number(s) or NCD ID number(s) associated with the denial.

The MCS carriers must ensure that the analysis and design is completed for any edit that may result in a denial based on an LMRP/LCD or NCD includes the LMRP/LCD ID number(s) or NCD ID number(s) associated with the denial.

The VMS carriers and PSCs must ensure the testing and documentation is completed for any edit that may result in a denial based on an LMRP/LCD or NCD and includes the LMPRP/LCD ID number(s) or NCD ID number(s) associated with the denial. All Medicare Summary Notices (MSNs) must contain the new MSN message for denials based on an LMRP/LCD or NCD.

The MCS carriers must ensure that the testing and documentation is completed for any edit that may result in a denial based on an LMRP/LCD or NCD includes the LMRP/LCD ID number(s) or NCD ID number(s) associated with the denial. All MSNS must contain the new MSN message for denials based on an LMRP/LCD.

D. Payment for Emergency Medical Treatment and Labor Act (EMTALA) - Mandated Screening and Stabilization Services

Under section 1862 of the Social Security Act, as amended by section 944 of the Medicare Modernization Act, in the case of an item or service provided by a hospital or critical access hospital pursuant to section 1867of the Social Security Act (EMTALA) on or after January 1, 2004, FIs must make determinations of whether the item or service is reasonable and necessary on the basis of information available to the treating physician or practitioner (including the patient's presenting symptoms or complaint) at the time the item or service was ordered or furnished by the physician or practitioner (and not only on the patient's principal diagnosis). The frequency with which an item or service is provided to the patient before or after the time of the service shall not be a consideration.

The National Uniform Billing Committee designated Form Locator 76 of the UB-92 claim form (837i 2300 HI segment, HI02-2. HI02-1 (the qualifier for HI02-2) must = ZZ. This HI02 is used only once per claim.) to be used for the ICD-9-CM code that represents the patient's reason for the visit in 1999. Recently CMS added edit criteria to require this on an outpatient claim Types of Bill (TOBs) 13X, 14X, 23X, 71X, 73X, 83X, and 85X. Only one diagnosis code may be shown on a claim as the reason for the visit, and that is recorded in Form Locator 76. At the provider's discretion, additional signs and symptoms codes not inherent in the principal diagnosis may be reported in Form Locators 68 through 75 (837i 2300 HI segment, HI01-2. HI01-1 (the qualifier for HI01-2) must = BF. Additional codes may be added in HI02 through HI12). The FIs shall instruct providers that they may use these fields when billing for items or services, including diagnostic tests, performed under EMTALA, and/or when billed with revenue codes 045X, 0516, or 0526 to assure appropriate payment. The system must scan these fields as well for payable diagnosis codes. For LCDs with frequency edits, you must turn off those frequency edits for these services.

The FIs may target medical review for potentially aberrant ED billing, but decisions must be based on the information available to the treating physician or practitioner, including the patient's presenting conditions. FIs will continue to perform their data analysis on EDs to ensure that there are no aberrant patterns of outliers.

The FIs shall reopen claims for ED services provided on or after January 1, 2004 that were previously denied prior to the issuance of this instruction if the provider so requests.

3.5.2– Categories of MR Edits

(Rev.174, Issued: 11-17-06, Effective: 10-01-06, Implementation: 10-06-06)

Because it is important to have the flexibility to modify MR edits based on workload demands and changes in provider behavior, contractors are encouraged to ensure that most MR edits are located in the table driven portion of the system and are not hard coded.

For reporting purposes, there are three kinds of prepayment edits:

A. Service-Specific Edits

These are edits that select claims for specific services for review. They may compare two or more data elements present on the same claim (e.g., diagnosis to procedure code), or they could compare one or more data elements on a claim with data from the beneficiary's history file (e.g., procedure code compared to history file to determine frequency in past 12 months).

B. Provider-Specific System Edits

These are edits that select claims from specific providers flagged for review. These providers are singled out due to unusual practice patterns, knowledge of service area abuses, and/or utilization complaints received from beneficiaries or others. These edits can suspend all claims from a particular provider or focus on selected services, place of service, etc. (e.g., all claims for holter monitoring from a given provider).

C. Random Edits

Contractors may no longer operate any random edits.

3.5.3 – CMS Mandated Edits

(Rev.174, Issued: 11-17-06, Effective: 10-01-06, Implementation: 10-06-06)

In past years, CMS created mandated edits that suspend certain claims for manual coverage and coding review. However, more recently, CMS has given the contractors the discretion to prioritize workload to effectively lower the error rate. CMS is now in the process of removing such mandated coverage and coding review edits from CWF, pricer, grouper, fee schedules, etc.

Contractors may override CMS mandated edits that suspend for manual coverage and coding review without performing review if one or more of the following conditions apply:

- The contractor does not have MR responsibility for the claim, or
- The contractor's data analysis/priority setting/ MR strategy does not indicate this service is a problem in their jurisdiction, or
- It is not a SNF (excluding swing beds) or HHA demand bill (these demand bills must be reviewed).

3.6.3 - Re-adjudication of Claims

(Rev.174, Issued: 11-17-06, Effective: 10-01-06, Implementation: 10-06-06)

This section applies to all three types of postpayment reviews (error validation reviews, statistical sampling for overpayment estimation reviews, and consent settlement reviews).

For each claim in the sample, contractors re-adjudicate claims by making a coverage, limitation of liability and/or coding determination in accordance with PIM, chapter 3, section 3.4.1. Contractors must document all items/services incorrectly paid, denied or under coded (e.g., billed using a HCPCS or other code that is lower than what is supported by the medical record). They report services newly denied as a result of re-adjudication as positive values and they report services that were denied but are reinstated as a result of re-adjudication as negative values. Contractors document the amount of the over/underpayment and how it was determined. Intermediaries must do this in conjunction with Audit/Reimbursement staff. (See PIM, chapter 3, section 3.8.4.) Contractors must assure that their documentation is clear and concise and includes the basis for revisions in each case (this is important for provider appeals). They include copies of the NCD, coverage provision in interpretive manual *or LCD* and any applicable references needed to support individual case determinations. Compliance with these requirements facilitates adherence to the provider or supplier notification requirements in PIM, chapter 3, section 3.6.5.

3.11.1.1 – Review of Data

(Rev.174, Issued: 11-17-06, Effective: 10-01-06, Implementation: 10-06-06)

Data analysis is an essential first step in determining whether patterns of claims submission and payment indicate potential problems. Such data analysis may include simple identification of aberrancies in billing patterns within a homogeneous group, or much more sophisticated detection of patterns within claims or groups of claims that might suggest improper billing or payment.

Data analysis itself may be undertaken as part of general surveillance and review of submitted claims, or may be conducted in response to information about specific problems stemming from complaints, provider or beneficiary input, fraud alerts, reports from CMS, other contractors, or independent government and *nongovernmental* agencies.

3.11.1.6 – Provider *Notification and Feedback*

(Rev.174, Issued: 11-17-06, Effective: 10-01-06, Implementation: 10-06-06)

Provider *notification and feedback* is an essential part of solving problems.

Provider notification and feedback means direct contact between *the contractor* and the provider through a telephone contact *or* letter *as a result of or directly related to a specific claim or group of claims reviewed on probe or complex medical review.* The overall goal of providing *notification and feedback* is to ensure proper billing practices so that claims will be submitted and paid correctly. Remove providers from medical review as soon as possible when they demonstrate compliance with Medicare billing requirements*, based on follow-up data analysis conducted by the MR department.*

Contractors shall send written notification to all providers when they are placed on medical review and removed from medical review. We recognize that some providers may remain on medical review for long periods of time, despite interventions and use of the PCA concepts. In the case of extended medical review activities, provide written notification at least every 6 months. Notification letters must be clear and concise and must include at least the following information: the reasons for medical review; previous review findings (if applicable); planned medical review (level of review and duration), potential for continuation of or increase in medical review levels (if identified problems continue, additional problems are identified, etc.); description of the specific actions the provider must take to resolve the problems identified in the medical review process.

When appropriate, an offer to provide individualized education *may be included in the notification letter, along with contact information for POE, the department which will be responsible for further educating on the topic. When inquiries are received in response to a provider notification or feedback letter, ONLY responses to those inquiries directly related to a specific claim or group of claims reviewed on probe or targeted medical review should be charged to Medical Review, in the appropriate CAFM activity code for the type of review performed.*

Comparative Billing Reports

Contractors can develop and issue comparative billing reports in 3 situations: (1) Included in provider-specific notification and feedback letter, (2) provider-specific reports for individuals who have requested a report, and (3) service-specific reports.

1) Provider-specific reports.

To address potential over-utilization, contractors may give provider-specific comparative billing reports to those providers that demonstrate the highest utilization for the services they bill, to be included in the feedback and notification letters issued as a result of probe or Targeted Medical Review. These reports must provide comparative data on how the provider varies from other providers in the same specialty payment area or locality. Graphic presentations may help to communicate the provider's billing pattern more clearly. Contractors may NOT charge a fee for providing these reports.

2) Provider-specific or specialty-specific comparative billing reports for requestors.

In order to provide good customer service, contractors may give provider-specific reports to providers or provider associations who request such a report. Contractors may charge a fee for providing these discretionary reports. However, any money collected must be reported as a credit in the applicable CAFM II Activity and accompanied with a rationale for charging the fee. Revenues collected from these discretionary activities must be used only to cover the cost of these activities, and may not be used to supplement other contractor activities. If contractors choose to make such reports available, contractors must describe on their website the mechanism by which a provider or provider association can request such a report and the fee for it.

3) Service-specific comparative billing reports.

When widespread problems are verified, contractors should refer that information to POE for possible website posting. Contractors may NOT charge a fee for posting these reports.

The contractor shall ensure that POE staff have ready access to copies of all MR provider notification and feedback letters so that POE staff will have this information available should a provider contact POE requesting education. If the problem identified by MR is of medium or high priority, a priority referral may also be made to POE, to alert POE staff to the degree of severity and educational need.

3.11.1.8 – Fraud

(Rev.174, Issued: 11-17-06, Effective: 10-01-06, Implementation: 10-06-06)

At any time, if the medical review detects possible fraud, refer the issue to the *appropriate program safeguard contractor*. See CMS Pub IOM 100—8, chapter 4, § 2.1- Examples of Medicare Fraud.

The PCA requirements do not apply when a fraud development is initiated.

3.11.1.9 – Track Interventions

(Rev.174, Issued: 11-17-06, Effective: 10-01-06, Implementation: 10-06-06)

Track *contacts* with individual providers through a provider tracking system (PTS).

The PTS will identify all individual providers and track all contacts made as a result of *actions taken by MR to notify the provider of and to correct identified problems*. Record the name of the person contacted in the PTS. Use the PTS to coordinate contacts with providers (e.g., medical *review contacts directly related to probe or complex medical reviews*). If a provider is contacted as a result of more than one problem, ensure that multiple contacts are necessary, timely and appropriate, not redundant. Coordinate this information with *the PSC* Benefit Integrity unit to assure contacts are not in conflict with benefit integrity related activities. *Also, maintain communication regarding these contacts with POE for any cases referred to that unit.*

The PTS should contain the date a provider is put on a provider specific edit for medical review. Reassess all providers on medical review quarterly to determine if their behavior has changed. Note the results of the quarterly assessment in the PTS. If the behavior has resolved sufficiently and the edit was turned off, note the date the edit was turned off in the PTS. When a provider appeals a medical review determination to the administrative law judge (ALJ), share appropriate information in the PTS with the ALJ to demonstrate

corrective actions that you have taken. This instruction does not alter the existing appeal process used by providers.

3.11.2 – Implementation

(Rev.174, Issued: 11-17-06, Effective: 10-01-06, Implementation: 10-06-06)

Contractors shall communicate with specific providers about the *aspects of PCA performed by Medical Review*. Include PCA as a regular part of your ongoing medical review training and new provider orientation training.

NOTE: Provider includes physicians, suppliers, etc. A definition of provider can be found in the PIM Exhibit 1.

3.11.3 – Vignettes

(Rev.174, Issued: 11-17-06, Effective: 10-01-06, Implementation: 10-06-06)

The following are examples of vignettes that may result from medical review accompanied by suggested administrative actions. This information should be used only as a guide. It is not meant to be a comprehensive list of possible vignettes or an inclusive list of appropriate administrative actions*. Also, contractor MR departments must include communication and follow-up with POE throughout the PCA process to ensure coordinated efforts toward problem resolution. The contractor shall ensure that POE staff have ready access to copies of all MR provider notification and feedback letters so that they may be prepared for provider requests for education and monitor for trends warranting widespread education (See CMS Pub 100-04, §20.3.4.2, for further information).*

1. Twenty claims are reviewed. One claim is denied because a physician signature is lacking on the plan of care. The denial reflects 7% of the dollar amount of claims reviewed. Judicious use of medical review resources indicates no further review is necessary at this time. Data analysis will determine where medical review activities should be targeted in the future.

2. Forty claims are reviewed. Twenty claims are for services determined to be not reasonable and necessary. These denials reflect 50% of the dollar amount of claims reviewed. One hundred percent prepayment review is initiated due to the high number of claims denied and the high dollar amount denied*. The contractor provides notification to the provider about specific errors made and makes a priority referral to POE to inform them of the severity of the problem.*

3. Forty claims are reviewed. Thirty-five claim*s* are denied. These denials reflect 70% of the dollar amount of claims reviewed. Payment suspension is initiated due to the high denial percentage and the Medicate dollars at risk. *The contractor provides notification to the provider about specific errors made and makes a priority referral to POE to inform them of the severity of the problem.*

4. Forty claims are reviewed. Thirty-three claims are denied. These denials reflect 25% of the dollar amount of the claims reviewed. The contractor provides *notification* to the provider about specific errors made. The contractor initiates a moderate amount (e.g., 30%) of prepayment medical review to ensure proper billing.

5. Thirty-five claims are reviewed. Thirty claims are denied representing 75% of the dollar amount of the claims reviewed. Many of the denials are because services were provided to beneficiaries who did not meet the Medicare eligibility requirements. *The contractor provides notification to the provider about specific errors made and makes a priority referral to POE to inform them of the severity of the problem.* A consent settlement offer is made but declined by the provider. A postpayment review of a statistical sample for overpayment estimation is performed and an overpayment is projected to the universe. Overpayment collection is initiated.

6. Twenty-five claims are reviewed. Five claims representing 5% of the dollar amount of the claims are denied. This supplier is known to the DMERC as one who has a significant decrease in billing volume when targeted medical review is initiated. The DMERC is concerned that this supplier may be selectively submitting bills when placed on medical review and chooses to continue some level of prepayment medical review despite the low error rate.

7. Twenty claims are reviewed. Ten claims are denied for lack of complete physician orders representing 65% of the dollar amount of the claims. The RHHI *issued a letter to inform* the home health agency about the denials and the reason for the denials. In response *to the notification letter*, the agency owner initiated a mandatory training program for select staff. The HHA was put on 30% prepayment medical review. Results of the review indicated an improvement in the error rate to 30% (based on dollars denied divided by dollars reviewed). On appeal, nearly all of the denials were overturned. The RHHI consults with the ALJ to understand why the cases are being overturned and consults with the regional office on appropriate next steps.

4.2.2.4 - Procedural Requirements

(Rev.174, Issued: 11-17-06, Effective: 10-01-06, Implementation: 10-06-06)

Contractors shall provide written procedures for personnel in *various* contractor components (claims processing, MR, beneficiary services, POE, intermediary audit, etc.) to help identify potential fraud situations. Include provisions to ensure that personnel shall:

- Refer potential fraud cases promptly to the *PSC* BI unit.

- Forward complaints alleging fraud through the second-level screening staff to the *PSC* BI unit.

- Maintain confidentiality of referrals to the *PSC.*

- Forward to the *PSC* BI unit documentation of the details of telephone or personal contacts involving fraud issues discussed with providers or provider staff, and retain such information in individual provider files.

In addition, PSC BI units shall ensure the performance of the functions below and have written procedures for these functions:

- Keep educational/warning correspondence with providers and other fraud documentation concerning specific issues in individual provider files (refer to §4.2.2.4.2 for retention of this documentation), so that PSCs are able to retrieve such documentation easily.

- Maintain communication and information flowing between the PSC BI unit, and the *DME* PSC, AC, or *MAC* MR staff, and as appropriate, intermediary *or MAC* audit staffs.

- Communicate with the *DME PSC*, AC or *MAC* medical review staff on all findings of overutilization and coordinate with the AC or *MAC provider outreach and education (POE)* staff to determine what, if any, education has been provided before any BI investigation is pursued.

- Obtain and share information on health care fraud issues/fraud investigations among carriers, *DME MACs*, *DMERCs* fiscal intermediaries (including rural home health intermediaries (RHHIs)), *A/B MACs,* PSCs, CMS, and law enforcement.

- Serve as a reference point for law enforcement and other organizations and agencies to contact when they need help or information on Medicare fraud issues and do not know whom to contact.

- Coordinate and attend fraud-related meetings/conferences and inform all appropriate parties about these meetings/conferences. These meetings/conferences include, but are not limited to, health care task force meetings and conference calls.

- Distribute fraud alerts to the appropriate parties. Share PSC BI unit findings on fraud alerts with PSCs within the appropriate jurisdiction and CMS.

- Work with the Primary GTL, Associate GTL, and SME to develop and organize external programs and perform training as appropriate for law enforcement, ombudsmen, grantees (e.g., Harkin Grantees or Senior Medicare Patrol) and other CMS health care partners (e.g., AoA, state MFCU).

- Serve as a resource to CMS as necessary. For example, serve as a resource to CMS on the FID, including FID training.

- Help to develop fraud-related outreach materials (e.g., pamphlets, brochures, videos) in cooperation with beneficiary services and/or provider relations departments of the ACs and *MACs*, for use in their training. Submit written outreach material to the Primary GTL, Associate GTL, and SME for clearance.

- Assist in preparation and development of fraud-related articles for AC and *MAC* newsletters/bulletins. The PSC BI unit shall send CMS CO a copy of these newsletters/bulletins to the following address:

  Centers for Medicare & Medicaid Services (CMS)
  Re: Newsletter/Bulletin Articles
  Division of Benefit Integrity Management Operations
  Mail Stop C3-02-16
  7500 Security Boulevard
  Baltimore, Maryland 21244

- Provide resources and training for the development of internal and new hire fraud training.

- Take appropriate administrative action on cases not accepted by OIG or other investigative agencies. At a minimum, provide information for recovery of identified overpayments and other corrective actions discussed in PIM, chapter 3, §§8ff and 9ff.

- Subject to the requirements in PIM, chapter 4, §4.4.1, provide support to law enforcement agencies for investigation of potential fraud and abuse, including investigations for which an initial referral to law enforcement did not originate from the PSC BI unit.

- Properly prepare and document cases referred to OIG/OI; two copies of a summary report of investigation shall be included with each fraud referral made to the OIG. The referral format listed in PIM Exhibits 16.1 and 16.2 shall be followed, unless

written guidance is provided by the applicable OIG/OI office and approved by the Primary GTL, Associate GTL, and SME. PSC BI units shall maintain files on the written guidance provided by the OIG/OI.

- Meet (in-person or telephone call) quarterly, or more frequently if necessary, with OIG agents to discuss pending or potential cases.

- Meet (in-person or telephone) regularly with DOJ to enhance coordination with them on current or pending cases.

- Furnish all available information upon request to OIG/OI with respect to excluded providers requesting reinstatement.

- *Report to the Primary GTL, Associate GTL, and SME* all cases that have been identified where a provider consistently fails to comply with the provisions of the assignment agreement.

- Maintain documentation on the number of investigations alleging fraud, the number of cases referred to OIG/OI (and the disposition of those cases), processing time of investigations, and types of violations referred to OIG (e.g., item or service not received, unbundling, waiver of co-payment).

- Conduct investigations (including procedures for reviewing questionable billing codes) and make beneficiary contacts (see PIM, chapter 4, §4.7.1 for details concerning investigations).

- *Coordinate and communicate with the MR unit within your organization if a DME PSC, and coordinate and communicate with the MR units in the ACs and MACs if an A/B PSC to avoid duplication of work.*

- *Obtain approval from the Primary GTL, Associate GTL, and the OI field office* before making an unannounced visit where fraud is suspected, and ensure that any other appropriate investigative agency is consulted with regard to the plan. PSC BI unit staff shall never engage in covert operations (e.g., undercover or surveillance activities). If OIG does not give approval, discuss this with the Primary GTL who will make the final decision.

- Obtain approval by e-mail, letter, or telephone call, and express any concerns (if a telephone call, follow up with a letter or e-mail) to the Primary GTL when the PSC BI unit is asked to accompany the OI or any other law enforcement agency going onsite to a provider for the purpose of gathering evidence in a fraud case (e.g., executing a search warrant). However, law enforcement must make clear the role of PSC BI unit personnel in the proposed onsite visit. The potential harm to the case and the safety of PSC BI unit personnel shall be thoroughly evaluated. PSC BI unit personnel shall properly identify themselves as PSC BI unit employees, and under no circumstances shall they represent themselves as law enforcement personnel or special agents. Lastly, under no

circumstances shall PSC BI unit personnel accompany law enforcement in situations where their personal safety is in question.

The ACs *and MACs* ensure the performance of the functions below and have written procedures for these functions:

- Ensure no payments are made for items or services ordered, referred, or furnished by an individual or entity following the effective date of exclusion (see PIM, chapter 4, §4.19ff for exceptions).

- Ensure all instances where an excluded individual or entity that submits claims for which payment may not be made after the effective date of the exclusion are reported to the OIG (see PIM, chapter 4, §4.19ff).

- Ensure no payments are made for an excluded individual or entity who is employed by a Medicare provider or supplier.

4.28 - Joint Operating Agreement

(Rev.174, Issued: 11-17-06, Effective: 10-01-06, Implementation: 10-06-06)

A Joint Operating Agreement (JOA) is a document developed by the PSC and the AC that delineates the roles and responsibilities for each entity specific to a Task Order.

As it applies to the PSC's task order, the JOA shall, at a minimum:

- Include a description and documentation of process/workflows that illustrate how the PSC and AC intend to interact with one another to complete each of the tasks outlined in the Task Order on a daily basis.

- Establish responsibility for who shall request medical records/documentation(s) not submitted with the claim.

- Ensure that the AC communicates to the PSC any interaction with law enforcement on requests for cost report information.

- Establish responsibility for how medical documentation that has been submitted without being requested shall be stored and tracked.

- Establish responsibility for how medical documentation that has been submitted without being requested shall be provided to the PSC if documentation becomes necessary in the review process.

- Mitigate risk of duplicate medical documentation requests.

- Ensure that there is no duplication of effort by the PSC and the AC (e.g., the AC must not re-review PSC work).
- Identify the JOA participants
- Describe the roles and responsibilities of the PSC and the AC
- Clearly define dispute resolution processes
- Describe communication regarding CMS changes
- Include systems information
- Include training and education
- Include complaint screening and processing (including the immediate referral by the AC second-level screening staff of provider complaints and immediate advisements to the PSC)
- Include data analysis
- Include suspension of payment
- Include overpayments processing
- Include excluded providers
- Include voluntary refunds
- Include incentive Reward Programs
- Include appeals
- Include provider enrollment
- Include system edits and audits
- Include requests for information
- Include FOIA and Privacy Act responsibilities
- Include interaction with law enforcement
- Include fraud investigations
- Include prepayment reviews

- Include postpayment reviews
- Include Harkin Grantees
- Include OIG Hotline referrals
- Include Self-Disclosures
- Include consent settlements
- *Include coordination on Provider Outreach and Education*
- Include securing email information
- Include JOA workgroup meetings
- Contain other items identified by CMS, the PSC, and/or AC

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6.1.6 - *Education*

(Rev.174, Issued: 11-17-06, Effective: 10-01-06, Implementation: 10-06-06)

Education is key to ensuring proper billing, both with the individual provider and with the SNF community as a whole. The contractor MR department shall inform the provider of the reason(s) for denial and of the correct way to bill. In addition to this MR notification and feedback, MR may refer the provider to POE for further education, as appropriate.

7.2.8.1 - Definitions

(Rev.174, Issued: 11-17-06, Effective: 10-01-06, Implementation: 10-06-06)

General data definitions. (See section 7.2.8.5.2 for a crosswalk between definitions and data items.)

The new system will require standard system data that can be classified under four different categories of activity measures: Effort, Workload, Denials, and Referrals. All definitions including the ones for fully automated edits and Correct Coding Initiative (CCI) edits apply to all program integrity activities and not just medical review (MR).

Definition 1 - MR: For the purposes of Program Integrity Management Reporting (PIMR) system, MR is defined as review of claims that occurs when review staff :

1) Make a coverage decision (benefit category, statutory exclusion, or reasonable and necessary) and a coding decision to determine the appropriate payment for claims;

or

2) *Investigate complaints to determine whether a corrective action was effective (e.g., an MR activity such as provider notification letter), or identify situations that require prepayment edits or the development of a local coverage determination (LCD).*

The MR requires the application of clinical judgment either as part of a review, in writing policies, or in the development of guidelines and processing instructions. For local edits, that input must be from the contractor staff. For national edits, input from the contractor medical/clinical staff is not necessary.

The MR can be performed either before or after the claim has been paid.

Generally, a line cannot result in MR workload or savings if it is not referred to MR. A line that potentially involves both MR and claims processing work should suspend to a claims processing reviewer, and that reviewer should refer the line to MR only if the claims processing reviewer cannot make a decision based on guidelines available to that reviewer.

- Do NOT consider the review as MR if it requires:

    1. Pricing Only;
    2. Coding Only; or
    3. Pricing and Coding only.

- Consider the review as MR if:

    1. Pricing is based on Medical review determination;

2. Coding is based on Medical review determination; or
3. Coding and Pricing are based on Medical review determination.

- If the review always results in the same conclusion when the same characteristics exist and all characteristics are enumerated or if it is a one-step routine decision, it should NOT be defined as Routine Medical review.

For example: “Always pay code J3490 when accompanied with the note Zantac," consider this claims processing review. If you must make the decision based upon the diagnosis that accompanies the claim, consider it MR.

- If an automated claims processing edit has already made a decision to pay, and the claim only suspends for pricing, consider the review automated claims processing and do not count it for MR workload or costs.

Definition 2 – Part B only: When this document refers to “Part B only”, it means the requirement applies only to carriers and DMERCs.

Definition 3 - Units: Reporting units may be reviews, claims, services, referrals, etc. Units are defined for each item. Units are usually reviews. Where they are not, the instructions clearly indicate the units contractors are to report.

Definition 4 - Coding Decisions: Where used in this PM, the term “coding decisions" generally refers to MR decisions. For example, coding decisions include each of the following:

> A contractor reviews product information for a Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) item, finds that the wrong code has been billed based upon the review of diagnoses codes and narrative information included on the claim/bill, changes the code to the correct code, and completes the claim.
>
> In the situation described above, the contractor denies the claim line with the wrong code and uses the message that the supplier has incorrectly coded the item.
>
> A local DMEPOS rebundling edit automatically denies a Column II code billed on the same date of service as a Column I code.
>
> The contractor determines that a service billed as a bilateral x-ray is a single view x-ray and indicates a down code to a single view x-ray in the remittance advice.

Include only coding decisions that require the application of clinical judgment as part of a review, in writing policies, or in the development of guidelines and processing instructions. For decisions based on local edits, that input must be from the contractor staff. For decisions based on national edits, input from the contractor medical/clinical staff is not necessary.

Definition 5 - Effort Data: Effort is the number of claims, line items, reviews, etc. to be reported.

Definition 5a - Cost - Dollars extracted from the Contractor Administrative and Financial Management (CAFM) system directly associated with each of the activities types described in later sections. Round to the nearest dollar.

Definition 5b - FTE - Full-time-equivalent (FTE) personnel counts extracted from CAFM directly associated with the direct personnel cost of each of the activity types described in later sections.

Definition 6 - Workload Data: Workload is the number of full-time-equivalents required to perform a task.

Definition 6a - Units - The number of workload units vary by activity types. Units may include the counts of edits, MRs, special studies, fraud cases, and data analysis. Where a unit is not specified, the unit desired is the number of reviews.

Definition 6b - Total No. of Claims - Number of claims a specific activity reviews during the reporting period.

Definition 6c - No. of Line Items - Number of individual lines a specific activity reviews during the reporting period.

Definition 6d - Billed Dollars - The actual charges submitted by providers or suppliers during the reporting period. Round to the nearest dollar.

Definition 6e -Allowed Dollars -The amount of the charges that are approved for payment on claims prior to MR. Round to the nearest dollar.

Definition 7 - Denial Data: Denials are our measure of savings in both dollars and workload units.

A denial is a claim for which a portion or all of the Medicare approved amount (initial charges allowed) was subsequently denied due to MR. The amount reported is not affected by reduction to zero due to offsetting, i.e., if what is paid after MR is reduced to zero by an offset, the difference between the approved amount and the amount before offset is the savings the contractor reports.

Definition 7a – Technical Denial: A technical denial for PIMR purposes, is defined as a denial that results because the claim cannot be read by the processing system or a payment decision cannot be made because sufficient information is not included on the claim. Examples of unreadable claims are ones that do not include a Health Insurance Claim Number or provider number. Examples of claims with insufficient information are claims that do not include a billed amount or procedure code.

Definition 7b - No. Denied Claims - Number of claims denied or reduced by each activity during the reporting period.

Definition 7c - No. Denied Line Items - Number of line items denied or reduced by each activity during the reporting period.

Definition 7d - Denied Dollars - The portion of the Medicare-approved amount (initial charges allowed) subsequently denied or reduced after MR. Include dollars saved through cutbacks or down codes that result from MR in this amount. Round to the nearest dollar. Standard systems are required to develop procedures to determine this amount by line item for each activity code and edit.

Definition 7e - Eligible Dollars - Amount of charges initially billed by the provider, supplier or beneficiary and eligible for payment on valid claims after MR. Count dollars eligible for MR even if they are subsequently denied by CWF processing. Round to the nearest dollar.

Definition 7f - Reversed Claims - Number of claims reversed during this period from claims denied or reduced during this or a prior period. We recognize that reversals always occur postpayment. The contractor is not required to match a reversal to the period in which the payment denial occurred.

More specifically, reversed claims are claims containing one or more edit denied/reduced items/services that were allowed as the result of contractor reviews, administrative law judge hearings, or civil court hearings during the quarter being reported. CMS includes re-openings in our definition of reviews. Reversals offset savings/denials to produce net savings/denials in the PIMR reporting.

Report reversals in the section that the denial that was reversed occurred, i.e., if the denial occurred prepayment, report its reversal in the prepayment section; if the denial occurred postpayment, report the reversal in the postpayment section.

Definition 7g - Reversed Line Items - Number of line items reversed during this period from or reduced during this or a prior period. We recognize that reversals always occur postpayment. The contractor is not required to match a reversal to the period in which the payment denial occurred.

Report reversals in the section that the denial that was reversed occurred, i.e., if the denial occurred prepayment, report its reversal in the prepayment section; if the denial occurred postpayment, report the reversal in the postpayment section.

Definition 7h - Reversed Dollars - Amount of dollars reversed during this period from dollars denied or reduced during this or a prior period. Round to the nearest dollar. We recognize that reversals always occur postpayment. The contractor is

not required to match a reversal to the period in which the payment denial occurred.

Report reversals in the section that the denial that was reversed occurred, i.e., if the denial occurred prepayment, report its reversal in the prepayment section; if the denial occurred postpayment, report the reversal in the postpayment section.

Definition 7i - Denial Reasons - Categories explaining why a claim was denied or reduced, or why an edit was developed. A listing is included in the reporting specifications. Current reason codes are used where possible; some existing reason codes may have to be mapped to the new codes for reporting purposes.

We summarized denial reasons for reporting at a very high level. That level gives us sufficient information to meet our current needs. We also attempted to stay at a high enough level of summary that contractors can easily comply with our requirements without having to revise their denial reason codes. Use the codes for both prepayment and postpayment reporting. To assist in assigning codes, section 2.8.4 contains a crosswalk between denial reason codes and the Medicare Summary Notice (MSN) codes used for remittance notices.

The denial reason codes are unique six character codes. Reason codes are:

APPLIES TO ALL CONTRACTORS

100001 = Documentation does not support service,
100002 = Investigational/experimental
100003 = Items/services excluded from Medicare coverage,
100004 = Requested information not received,
100005 = Services not billed under the appropriate revenue or procedure code (include denials due to unbundling in this category),
100006 = Services not documented in record,
100007 = Services not medically reasonable and necessary,
100008 = Skilled Nursing Facility demand bills,
100009 = Daily nursing visits are not intermittent/part time,
100010 = Specific visits did not include personal care services,
100011 = Home Health demand bills,
100012 = Ability to leave home unrestricted,
100013 = Physician's order not timely,
100014 = Service not ordered/not included in treatment plan,
100015 = Services not included in plan of care,
100016 = No physician certification (e.g., Home Health), and
100017 = Incomplete physician order, and
100018 = No individual treatment plan
100019 = Other.

Where a denial is due to multiple reasons, use the code for the reason that was most responsible for the denial.

Definition 7j - Overpayment Assessments Dollars -. Amount in dollars from those that were paid in error and should be collected from the provider, supplier or beneficiary. Report extrapolated dollars. Round to the nearest dollar.

Definition 7k - Overpayment Assessments Claims - This item applies to postpayment reporting. Number of claims from those that were paid in error and should be collected from the provider, supplier , or beneficiary. Report number of claims from the sample that were in error.

Definition 7l - Overpayment Collected Dollars - Amount in dollars from those paid in error and collected from the provider, supplier , or beneficiary during the reporting period. Round to the nearest dollar. Where collected dollars attributable to MR cannot be distinguished from collected dollars attributable to other activities, allocate collected dollars based on cumulative overpayments assessed and not collected in each category.

Definition 7m - Overpayment Collected Claims - Number of claims from those paid in error and collected from the provider, supplier , or beneficiary during the reporting period. Round to the nearest dollar. Collected overpayments do not have to be linked to the specific claims from which they resulted. Include interest in amounts reported.

Definition 8 - Referral Data: Referrals are the number of issues or cases transferred between entities internal (e.g., the MR unit to professional relations) or external (e.g., the MR unit to a state licensing agency) to the contractor. Accumulate referral data by claim. The Program Safeguard Contractor (PSC) may *be required* to supply CMS with data on the outcome of referrals, i.e., accepted and referred to OIG. A referral does not include such activities as a medical reviewer calling a provider to clarify or correct a billing error. MR units do not have to report on referrals made by *the PSC* BI unit. A referral occurs only when one entity refers a provider or case to an entity other than a provider. In most instances, referrals occur postpayment; however, they may occur prepayment. Report referrals in the section (i.e., prepayment or postpayment) to which they apply.

Definition 8a - $ Referred to BI Unit or PSC - Dollar amount (i.e., questioned dollars) referred to the BI unit or PSC. These are referrals within the contractor's organization. A referral may be an individual claim; a number of claims or line items; one or more providers; an issue; or a problem. The dollar value of all fraud related referrals made by the contractor should be included in this count.

Definition 8b - # Referred to BI unit or PSC - Number of referrals made to the BI unit or PSC at the contractor. A referral may be an individual claim; a number of claims or line items; one or more providers; an issue; or a problem. Report the number of referrals, not the number of claims; line items; or providers. These are

referrals within the contractor's organization. All fraud related referrals made by the contractor should be included in this count.

Definition 8c - # Referrals Accepted - Number of referrals accepted by the *PSC* BI unit. These are referrals within the contractor's organization. A referral may be an individual claim; a number of claims or line items; one or more providers; an issue; or a problem. Report the number of referrals, not the number of claims; line items; or providers.

Definition 8d - $ Referrals Accepted - Dollar amount (i.e., questioned dollars) of referrals accepted by the BI unit or PSC. These are referrals within the contractor's organization.

Definition 8e.1 - Other Referrals - Include actions, such as a referral for provider education based on MR, if you determine that the provider or supplier needs further claim submission education, either individually or in a group setting. The referral may be from either prepayment or postpayment review and occurs internal to the contractor organization.

Generally, if the work of the person or unit to which you refer a claim line is charged to the same MR line as your work is charged, do not count the referral as an "Other referral." If the work of the person or unit to which you make the referral is not charged to the MR line as your, count it as an "Other referral."

For example: A referral for continuation of PCA should not be considered other referral. Count each prepayment PCA as a manual review.

Definition 8e.2 - Other Referral Reason Codes - These are unique character codes that apply to Other Referrals or Actions. Reason codes include:

200001 = Develop a local coverage determination (LCD)

200002 = Overpayment recovery - Overpayment recovery occurs when a contractor assesses an overpayment and refers an account for overpayment recovery. Overpayment recovery does not have to have occurred for this code to be used. An example of prepayment overpayment recovery is the denial of a claim previously paid when a contractor determines that a submitted claim results in a provider exceeding five surgeries in one day and there is a multiple surgery indicator of 2 for the claim. For postpayment reporting, enter this code and overpayment amount, where applicable. If this code is used, an amount for overpayments assessed should be entered for either the prepayment section 1 or in the postpayment report,

200003 = Requirement of a corrective action plan (e.g., clarifications of coding guidelines),

200004 = Suspension of Payment,

200005 = Education

200006 = Development of denial rationales (clarification as of 01/17/01). This code is used when a claim is referred for the development of internal comments for a claim denial. This code should be used when a contractor is developing a rational for denial of new benefit types prepayment or for denial of claims with payment problems that the contractor has newly identified postpayment,

200010 = Additional or provider specific MR,
200011 = Comprehensive MR,
200012 = Focusing MR because of percent increase in a measure of provider activity,
200013 = Continuous prepay MR (e.g., requiring that a percentage of or all claims from a provider that meet a given criteria; be reviewed regardless of whether they fail any other edit, and someone other than the staff who makes the decision implements the action),
200014 = Referral to a *PSC* BI unit,
200015 = Develop an edit,
200016 = Other,
210017 = Data analysis, and
210018 = Special studies.

This field may be blank if there were no referrals for reasons other than fraud.

Definition 8e.3 - Dollars Referred to Other - Dollar amount (i.e., questioned dollars) referred as a result of actions, such as a referral for provider education based on MR, if you determine that the provider or supplier needs further claim submission education, either individually or in a group setting. The referral may be from either prepayment or postpayment review and occurs internal to the contractor organization.

Definition 9 - General Reporting Levels

Depending on the situation, the data elements defined above are reported by several different categories or levels of detail. These levels include: Contractor Number, Year/Month, Provider Type, Bill/Subtype, Edit Code, and Activity Type. The levels are defined below.

Definition 9a - Contractor Number - A unique number CMS assigned to each contractor for Contractor Reporting of Operational and Workload Data (CROWD) reporting purposes. You must report for each contract number served by the standard system. Zero fill this field to the left where necessary.

Definition 9b - Year/Month - The fiscal year and month in which the data is reported. The format is YYYY/MM. For example, the first month (i.e., October, 1998) of fiscal year 1999 is 199901. **Note that the date for the example is not a calendar date.**

Definition 9c - Provider Type - Provider types are defined in section 2.8.3. For Part B, code as "Physician" if the study addresses both physicians and suppliers. Zero fill this field to the left where necessary.

Definition 9d - Bill/Subtype - Bill types will be used in the future for Part A, and Subtypes are for Part B. These are the second level of indenture for the type of entity providing the services or supplies (e.g., surgery). Subtypes and bill types may be based on procedure codes. Procedure code modifiers are not used to identify bill type or bill subtype. In deciding on the bill types for Part B, base the decision on the specialty of the performing (i.e., rendering) provider if there is a billing number for that provider. Otherwise, use the specialty of the rendering provider if there is no performing provider billing number. (See section 2.8.3). Zero fill this field to the left where necessary.

Definition 9e - Edit Code - Locally developed edits are edits for which the contractor developed some or all of the logic. These do not include Correct Coding Initiative (CCI) or National edits unless the contractor modified the edit to include other logic; report a modified CCI, or National edit as a local edit only and do not include it in the CCI or national categories. The data for locally developed edits must be reported for each individual edit by edit code. Data at the automated edit level applies only to specific prepayment activity types. That decision reflects the current needs of CMS, i.e., to identify the effectiveness and costs of manual edits. We do not need the same level of detail on national edits as we do on local edits. If additional needs arise in the future, we will either revise PIMR (if the requirement is long term) or make a special request (immediate and short term needs).

Each contractor assigns their own numbers to the edits and describes the edits (i.e., specify procedure, diagnosis, and type of provider) in a registry that is a separate part of the system. Edit numbers are not standardized across contractors.

An edit code is described in the manual entry database based on procedure code, diagnosis code, and specialty. A narrative description of each code is also entered as part of the description. The description includes a description of criteria applied by the edit. The lists of procedure codes and diagnosis codes may be given in the form of ranges of codes. The edit code should correspond to an action code where possible. In the case of procedure code/diagnosis code pair edits, ranges may be used to describe the edits.

One edit may describe both physician and non-physician services. For example, if an edit tests for the number of laboratory tests a provider may perform on a beneficiary, the limit applies to both physicians and non-physicians.

If a claim suspends for manual review for reasons other than failing a MR automated edit, report it in the automated edit category.

Classification of edit data into Categories I, II, and III no longer applies in PIMR. We currently do not have a need for that information. The edit description provided for each edit indicates if the edit is provider specific. If the need arises to obtain data by provider specific edits, we can do that on an ad hoc basis.

The DMERC rebundling edits are defined as locally developed edits for purposes of these requirements.

Do not include information on global surgery edits that are part of the Medicare Fee Schedule database in PIMR reporting.

Zero fill this field to the left where necessary.

Other names contractors use for edit codes are: "medical policy screen number," "UR screen number," and "UR edit number."

Definition 9f - Activity Type - A set of MR activities performed by the contractor. There are essentially five different categories of activities: Prepayment MRs, Other Prepayment Reviews, Postpayment MRs, Claims Processing, and Other Activities. They are defined below:

Definition 9f.1 - Prepayment MR - These reviews occur prior to payment decisions. A manual prepay MR is a manual review of claim data or supporting documentation, when necessary, by health professionals or trained MR staff. They include manual reviews that result from automated edits (not automated reviews) fully or partially suspending claims for MR. These are reviews that result in human review whether reviewed initially by automated MR edits or not. If a claim suspends for manual review for reasons other than failing a MR automated edit, report it in the automated edit category.

The above data elements are transferred for the reporting period for each of the following activities:

Definition 9f.1a - Automated Edits: An automated edit is one that never suspends for human intervention. It is an edit that pays or denies claims, i.e., processes the claim to completion without stopping for resolution. See PIM, Chapter 3, section 5.1 for further discussion of automated prepayment review.

Some automated edits automatically request documentation from a provider without human intervention. If such an edit requests documentation and none is received, consider the review automated. If documentation is received and medical review is performed, consider the review complex manual.

Determine if a claim falls into the automated edit category on a claim by claim basis. Report the number of denials that result from automated edits where this element is required. Note that PIMR does not ask for reports on automated edit payments; it asks only for reports on automated edit denials.

Fully automated MR edits result in a claim or line item being paid or denied without manual review. It is implemented with systems edits that compare two or more data fields on the claim or other file (e.g., history file). For example, automated edits can be established to compare the procedure code to diagnosis code or the procedure code to a patient's sex. In those instances where prepayment review is automated, the contractor may specify, thorough their local medical review policy, the circumstance under which they will deny the service. When a national coverage policy or *local coverage determination* clearly indicates that under certain circumstances a service is never covered, contractors may also automatically deny the services under those circumstance without stopping the claim for manual review, even if documentation is attached.

An automated review occurs when a claim/line item passes through the contractor's claims processing system or any adjunct system and is denied in whole or in part because the service(s) is non-covered or not coded correctly; that means that an automated review is reported in PIMR only when it denies a part or all of a line item. The data referred to here is any resulting data that does not become associated with a manual MR. Specific data elements are transferred for the reporting period categorized as one of the following edit types:

Definition 9f.1a.1 - Locally Developed - edits for which the contractor developed some or all of the logic. This does not include CCI or National edits unless the contractor has modified the edit to include other logic. The data for locally developed edits must be reported for each individual edit by edit code.

Definition 9f.1a.2 - National - fully automated MR edits that CMS creates and the contractors do not modify. They are exactly the same for all FIs; they allow no deviations whatsoever. Basically, these edits encompass all

(A) Non-covered services, i.e., services (1) specifically stated as non-covered by the Coverage Issues Manual (CIM) (2) for which a CPT code has been assigned and (3) that can be fully automated without any manual intervention, or

(B) Any covered service where CIM extends coverage only for certain conditions.

Examples of national automated edits include:

Any National Policy driven by diagnosis. (Example: 23 new National Lab Policies that have not been issued),

The OCE module triggers an edit that sets a reason code for medical review.

Edits set up for services that are always non covered. (example: routine physicals, V code denials as routine, etc), and

Edits that auto-deny for assistants at surgery.

In other instances where CMS has specified coverage conditions but latitude is given to the contractor to limit coverage (i.e., develop *LCD* to apply diagnoses) in order to auto-adjudicate, consider those services as automated locally developed edits because diagnoses could be slightly different in each State.

See section 2.8.6 for further discussion of national edits based upon program documents as of February 25, 2002.

The data reported for national edits are not reported for each individual edit, but as a sum. Only data from claims denied by national edits are required for national edits.

Activity code 21001N, national automated edits, includes all edits specifically required by CMS except CCI. National automated edits never suspend for manual review. All criteria in them may be applied via computer.

Definition 9f.1a.3 - CCI - CCI edits that some contractors may operate as partially automated MR edits (ones that sometimes suspend for manual review) and that are developed under the CCI and are provided to the contractor. CMS considers CCI edits fully automated even if a contractor operates them as partially automated. The data reported for CCI edits will not be reported for each individual edit, but will be reported as a sum. Only data from claims denied by CCI edits will be required for "CCI edits."

Definition 9f.1b - Manual Edits

Definition 9f.1b.1 - Manual Routine Reviews - Routine review uses human intervention, but only to the extent that the claim reviewer reviews a claim or any attachment submitted by the provider. This includes a review of any of the contractor's internal documentation, such as claims history file or policy documentation. It does not include extensive review of medical records. A review is considered routine if a medical record is requested from a provider and not received. Routine reviews refer to routine MRs conducted on a continuing basis and target all claims that meet an established or pre-existing set of criteria. Include prior

authorization reviews in this category. Include in this category adjustments for which you 1) did not request medical records and 2) did no medical review previous to the adjustment.

Definition 9f.1b.2 - Manual Complex Reviews - Complex review goes beyond routine review. It includes the request for, collection of, and evaluation of medical records or any other documentation in addition to the documentation on the claim, attached to the claim, or contained in the contractor's history file. Review requiring use of the contractor's history file does not make the review a complex review. A review is not considered complex if a medical record is requested from a provider and not received. Manual Complex Reviews are complex MRs conducted on a continuing basis and targeted at all claims that meet an established or pre-existing set of criteria. If sufficient documentation accompanies a claim to allow complex review to be done without requesting additional documentation, count the review as complex. For instance if all relative pages from the patient's medical record are submitted with the claim, complex MR could be conducted without requesting additional documentation. Only clinician reviewers may perform complex review (i.e., review that involves extensive evaluation of medical records) for the purpose of making a coverage or coding determination. Include in this category adjustments for which you: 1) did request medical records; and 2) did no medical review previous to the adjustment. Include DMERC Advanced Determinations of Medicare Coverage (ADMC) reviews in this category.

Definition 9f.1b.3 - Prepay Complex Probe Reviews - Error validation reviews, also known as "probe" reviews. See PIM chapter 3, section 2 for more information about probe reviews.

Definition 9f.1b.4 - Prepay Complex Provider Specific Reviews. This is complex manual prepay review that determines if a provider or a group of providers are providing non-covered or medically unnecessary services. They are not probe reviews

Definition 9f.1b.5 - Prepay Complex Service Specific Reviews - This is complex manual prepay review that determines if a service or a group of services are providing non-covered or medically unnecessary services. They are not probe reviews. Include DMERC Advanced Determinations of Medicare Coverage (ADMC) reviews in this category.

Definition 9f.1b.6 - Re-openings - This is complex or routine review that is done as a result of re-review of the automated review of a previously denied or partially denied claim. Do not count more than one re-opening per claim. Re-openings include both additional documentation requests that contractors decide to process and denials returned from the formal appeals process that contractor MR staff might need to re-process.

Definition 9f.1c - Other Prepayment Reviews

There are other prepay reviews that are not a result of partially automated or manual edits suspending claims for manual review. Those reviews are the result of special requests.

The PIMR will not require specific review activities such as Directed OIG reviews or directed law enforcement reviews. Review requirements will be set by other program instructions or, as in the case with the examples, by requests from agencies outside of CMS. The PIMR instructions indicate only what contractors are required to report.

The following provides a definition of each review:

Definition 9f.1c.1 - Court Ordered MRs - A court ordered MR is a review that is required by a judicial order as evidenced by a subpoena or writ and not requested by law enforcement, the OIG, a PRO, *or* the *PSC* BI unit.

Definition 9f.1c.2 - Directed BI unit or PSC Reviews - Prepay reviews directed by or directly supporting the BI unit or PSC. These are reviews that the MR unit did not start or that the BI unit or PSC requested after the MR unit started the review.

Definition 9f.1c.3 - Directed Law Enforcement Reviews - Prepay reviews directed by or directly supporting law enforcement. These are reviews that the MR unit did not start or that law enforcement requested after the MR unit started the review.

Definition 9f.1c.4 - Directed OIG Reviews - Prepay reviews directed by or directly supporting, the HHS Office of the Inspector General. These are reviews that the MR unit did not start or that the OIG requested after the MR unit started the review. Include CFO audit activities in this category.

Definition 9f.1c.5 - Directed *QIO* - Prepay reviews directed by or directly supporting the *quality improvement* organization. These are reviews that the MR unit did not start or that the *QIO* requested after the MR unit started the review.

Definition 9f.1c6 - Third Party Liability (TPL) or Demand Bill Claim Review - Demand bills are bills submitted by the SNF at the beneficiary's request because the beneficiary disputes the provider's opinion that the bill will not be paid by Medicare and wishes the bill to be submitted for a payment determination. The demand bill is identified by the presence of a condition code 20. The SNF must have a written request from the beneficiary to submit the bill, unless the beneficiary is deceased or incapable of signing. In this case, the beneficiary's guardian, relative, or

other authorized representative may make the request. See the PIM, chapter 6.1.1B, for additional detail.

Definition 9f.2 - Postpayment MRs - Postpayment reviews occur after a decision to pay is made. They include:

Postpayment routine manual review (see definition below);

Postpayment complex provider specific reviews (see definition below);

Postpayment complex service specific reviews (see definition below);

Postpayment complex probe reviews (see definition below);

Reviews of claims for purposes other than CMR, such as investigating a complaint or following up to determine if an educational contact resulted in changed behavior;

Reviews that provide the basis for a decision to initiate suspension of payment for a given provider;

Reviews that identify situations that require prepayment edits or *LCDs*; and

Reviews that result in referrals to the *PSC* BI unit with recommendations for administrative sanctions (including civil and criminal prosecution) for providers who fail to correct their inappropriate practices.

Definition 9f.2a - Postpayment Routine Manual Review -

For routine manual postpayment review, the claim reviewer reviews a claim or any attachment submitted by the provider. This includes a review of any of the contractor's internal documentation, such as claims history file or policy documentation. It does not include review of medical records by a clinician. If a non-clinician performs review of medical records, report it as routine review. A review is considered routine if, after routine manual medical review, a medical record is requested from a provider and not received. Routine reviews refer to routine MRs that target all claims that meet an established criteria. Include prior authorization reviews in this category.

Definition 9f.2b - Postpayment Complex Manual Review -

Complex review goes beyond routine review. It includes the request for, collection of, and evaluation of medical records or any other documentation in addition to the documentation on the claim, attached to the claim, or contained in the contractor’s history file. Review requiring use of the contractor's history file does not make the review a complex

review. A review is not considered complex if a medical record is requested from a provider and not received. Manual complex reviews are complex MRs that targeted at all claims that meet an established set of criteria. If sufficient documentation accompanies a claim to allow complex review to be done without requesting additional documentation, count the review as complex. For instance if all relevant pages from the patient's medical record are submitted with the claim, complex MR could be conducted without requesting additional documentation.

Complex MR is a process that includes the review of medical records and other documentation to determine if a provider or a group of providers are providing non-covered or medically unnecessary services; or, if a specific service or a group of services is non-covered or medically unnecessary. Complex MRs are usually targeted at providers or services that have demonstrated aberrant billing or practice patterns. They also serve as the basis for overpayment assessment and projection. You may perform Complex MRs at the contractor's facility or at a provider's or supplier's facility. Location does not determine if the review is complex. Include all progressive corrective action (PCA) postpayment reviews in complex postpayment MRs. There are three types of complex postpayment review:

Definition 9f.2b.1 Postpayment Complex Provider Specific Reviews -

This is Complex Manual Postpay Review that determines if a provider or a group of providers are providing non-covered or medically unnecessary services. This is not a probe review.

Definition 9f.2b.2 - Postpayment Complex Service Specific Reviews -

This is Complex Manual Postpay Review that determines if a specific service or a group of services is non-covered or medically unnecessary. This is not a probe review.

Definition 9f.2b.3 - Postpayment Complex Probe Reviews - Error validation reviews, also known as "probe" reviews (see PIM chapter 3, section 2 for more information about probe reviews

The PIMR does not require specific review activities, such as postpayment reviews. Review requirements will be set by other program instructions or by requests from agencies outside CMS. PIMR instructions only indicate what contractors are required to report.

Definition 9f.2c - Directed Reviews - Postpay reviews directed by or directly supporting a unit outside of the Medical Review Unit. These are

reviews that the MR unit did not start or that the outside unit requested after the MR unit started the review. The different types of directed reviews are described below.

Definition 9f.2c.1 - Directed *PSC* BI unit Reviews - Postpay reviews directed by or directly supporting the BI unit or PSC. These are reviews that the MR unit did not start or that the BI unit or PSC requested after the MR unit started the review.

Definition 9f.2c.2 - Directed CMS CFO Reviews - Postpay reviews directed by or directly supporting the CFO Audit. These are reviews that the MR unit did not start or that CMS or OIG requested to support the CFO audit after the MR unit started the review.

Definition 9f.2c.3 - Directed OIG Reviews - Postpay reviews directed by or directly supporting the Department of Health and Human Services Office of the Inspector General (DHHS OIG). These are reviews that the MR unit did not start or that the OIG requested after the MR unit started the review. Include CFO audit activities in this category.

Definition 9f.2c.4 - Directed Law Enforcement Reviews - Postpay reviews directed by or directly supporting law enforcement other than the DHHS OIG. These are reviews that the MR unit did not start or that law enforcement other than the DHHS OIG requested after the MR unit started the review.

Definition 9f.2c.5 - Directed ORT or Wedge Reviews - Postpay reviews performed under Operation Restore Trust (ORT) or reviews that support joint agency/State MR activities. These are reviews that the MR unit did not start or that ORT requested after the MR unit started the review.

Definition 9f.2c.6 - Directed PRO - Postpay reviews directed by or directly supporting the peer review organization (PRO). These are reviews that the MR unit did not start or that the RO requested after the MR unit started the review.

Definition 10 - Claims Processing - Claims processing involves information from a contractor's claim processing system. A claim is an electronic or paper request submitted in the prescribed CMS format to contractors for payment for Part B health services rendered by a provider (e.g., physician, or supplier) to a Medicare beneficiary. Data is required for specific data elements for the following categories:

Definition 10a - Claims Received - The number of provider/supplier/beneficiary requests for payment received within a given period that undergo review in accordance with CMS regulations and manual instructions. The claims are paid, denied ((clarification 01/17/01) or reduced), or suspended.

Definition 10b - Claims Paid - Claims reviewed and adjudicated that meet the claims payment and MR criteria for payment for the reporting period.

Definition 10c - Claims Available for MR - Claims considered valid by the contractor's claims processing function, i.e., claims that would have been paid if they had not gone to MR. Not included in this total are claims that are technically denied for reasons such as incomplete provider or patient demographic data or claims that are not subject to MR by the contractor.

Definition 10d - Line Items Paid - Line items reviewed and adjudicated that meet the claims payment and MR criteria for payment for the reporting period.

Definition 11 - Other Activities - Other activities that contractors perform require specific data. Those activities are described below:

Definition 11a - Data Analysis - Data analysis is defined as the review of claims information and other related data sources to identify patterns of over utilization or abuse by claim characteristics individually or in the aggregate.

Operationally, data analysis is all activities needed to identify aberrancies and to monitor the effectiveness of certain PI activities. Data analysis activities are:

(1) **Definition 11a.1 - Detection analysis** - This analysis is conducted for the purpose of identifying where PI problems exist. It includes the following activities:

- Identification of problems requiring prepayment edits, including the determination of measurements to be used in an edit;

- Analysis of claims information in the form of a table to identify or verify aberrancies, e.g., profiling of physicians or other provider profiling. Specific examples are Ratios I or II or Focused MR reports, up coding reports, over utilization reports, or concurrent care reports;

- Identification of problems requiring *LCDs*, including all activities required identify the problems and to identify problems that necessitate the development of an *LCD*;

- Acquiring data needed to decide if an edit is necessary;

- Requesting and receiving claims data necessary to identify the values to which submitted information is to be compared;

- Conducting training for staff involved in PI data analysis; and

- Participation on CMS PI data analysis workgroups.

(2) **Definition 11a.2 - Effectiveness analysis** -- This analysis is conducted for the purpose of evaluating the effectiveness of contractor actions to correct PI problems once the problems have been verified. It includes the following activities:

- Analysis of claims information in the form of a table to monitor the effectiveness of *LCDs*, and referrals from the MR unit to the *PSC* BI unit, or overpayment collection unit, e.g., profiling of physicians or other provider profiling. Specific examples are Ratios I or II or Focused MR reports, up coding reports, over utilization reports, or concurrent care reports.

- Initial evaluation and quarterly reevaluation of edits to decide their effectiveness. In this category, include the gathering of data and analysis of information in the form of a table, as well as computer time needed to produce information in table form.

- Conduct of evaluations to determine the overall effectiveness of PI activities.

Definition 11b - Special Studies - Special studies are defined as activities or projects with unique identifications designed to develop and demonstrate a new approach to fraud, abuse, or waste protection. Special studies include data collections, analyses, and surveys at the request of central office or ROs that are classified in other categories for PIMR reporting.

Definition 11c - Edit Development - Edit development is the effort necessary to create a computerized logic test developed with the assistance

of health professionals that compares the data elements on a Medicare claim for the purposes of: (1) making a coverage or local coding determination; or (2) suspending a claim so such determinations can be made by health professionals or trained MR staff prior to payment of the claim. Use the term edit instead of "screen or audit."

Definition 11d - Contractor Policy Development - Contractor policy development involves determining that a local coverage decision (LCD) is needed, using or adapting an existing *LCD* or model policy, or developing an *LCD* using medical consultants, input from professional organizations, and information from medical literature to address aberrant utilization under benefit category for an item/service.

Definition 12 - Miscellaneous Postpayment Definitions

Definition 12a - Review ID - This is a number PIMR automatically assigns as records enter the system. Contractors should leave this field blank. PIMR uses the number to uniquely identify each study.

Definition 12b - Claims Reviewed - This is number of claims reviewed as part of a postpayment review. This is the number of claims not the number of line items or providers. This figure will give CMS and idea of the amount of effort required to request medical records for a study and a claims level estimate of the number of lines per record when combined with the number of line items entered in a lines reviewed field (S8).

Definition 12c - Review Date - The beginning date of the postpayment review, i.e., the date that medical records are requested for the study.

Definition 12d - Updated by - The PIMR user ID of the person who last updated the record for the study.

Definition 12e - Case Code - The contractor supplies and tracks this number. It could be the control number the contractor uses in their case tracking system or a number assigned by the MR staff to manually track reviews. The purpose of the number is to make it easy for contractors to find studies in the PIMR system and update them as the contractor obtains additional information, e.g., results of appeals or overpayment collections, on the study.

7.8 – The Quarterly Strategy Analysis

(Rev.174, Issued: 11-17-06, Effective: 10-01-06, Implementation: 10-06-06)

The problem-focused, outcome-based strategy (IOM 100-8, Chapter 1) provides a continuous feedback process that will assist the contractor with the management of their *MR program*. To assist in the feedback process, the contractor shall utilize a quarterly strategy analysis (QSA). The PSC's shall follow the QSA guidelines to the extent they can report on the elements they are responsible per their individual SOW. The goals of the QSA are to:

- Improve the quality of information that will assist in the creation of outcome-based strategies.

- Assist the contractor in monitoring progress toward resolution of targeted problems.

- Assist the contractor in performing analyses of the *MR* program and the allocation of resources.

- Provide CMS with more specific information on how program funds are being used to reduce the claims payment error rate.

The QSA shall address each problem identified in the strategy and the progress toward the projected outcomes. Monitoring the actions taken toward rectifying targeted problems will allow for early evaluation of the effectiveness of the interventions used. Close monitoring of the progress toward projected outcomes is crucial in alerting the contractor's *MR* management of when shifts in workload, targets, or resources will be needed. Shifts in the strategy are expected and should be identified in the QSA.

The contractor shall develop and submit a QSA that focuses on the progress made in the implementation of the contractor's *MR* Strategy. The QSA will be problem and outcome focused, and will continually assess and evaluate the interventions being performed during the quarter to rectify the problems. The QSA will be an on-going tracking/reporting tool that will span across consecutive quarters and will not begin and end with the given fiscal year. The contractor shall also address quality assurance (QA) monitoring activities being performed in concurrence with the strategy and chosen interventions. QA activities shall include any follow-up activities performed to ensure resolution of problems addressed in the past.

In analyzing the activities for each problem, it may become evident that there needs to be a shift in workload or focus. Any shift in strategy should be identified in the QSA. If a shift in strategy impacting workload and/or dollars becomes evident, the contractor shall identify the specific activity line(s) impacted (increased or decreased) and provide the rationale for any redistribution of workload and funds amongst the activity lines and contractor sites in the QSA. Any shift of this nature impacting workload and/or costs would necessitate an *MR* Strategy revision. In addition, the contractor shall provide an analysis of any site-specific variance between the fiscal year 2007 (FY 07) notice of

budget approval (NOBA) and the reported quarterly cumulative Interim Expenditure Report (IER) workload and costs. Furthermore, the contractor shall provide explanations for variances as defined by the parameters in the following chart.

Required Variance Analysis Reporting for Medical Review (MR) Activity Codes
(use this as a guideline for Variance Analysis reporting only)

		Cost	Wrkld #1	Wrkld #2	Wrkld #3
21001	**Automated Review**	**+/- 5%**			
21002	**Routine Manual Review**	**+/- 5%**	**+/- 10%**		
21007	**Data Analysis**	**+/- 5%**			
21010	**TPL**	**+/- 5%**	**+/- 10%**		
21100	**PSC Support Services**	**+/- 5%**			
21206	**Policy Reconsideration/Revision**	**+/- 5%**	**+/- 10%**		
21207	**MR Program Management**	**+/- 5%**			
21208	**New Policy Development**	**+/- 5%**	**+/- 10%**		
21220	**Complex Manual Probe Review**	**+/- 5%**	**+/- 10%**		
21221	**Prepay Complex Review**	**+/- 5%**	**+/- 10%**		
21222	***Postpay Complex Review***	***+/- 5%***	***+/- 10%***		

1) The contractor shall provide explanations for variances that fall outside of the above parameters
2) Please note that a variance analysis may not be required for NOBA/IER variance amounts < $5,000
3) Please note that the variance analysis should be site specific.
4) A copy of the variance analysis should be sent to the regional office.

This chart is included as a guideline to contractors for variance analysis reporting, and is not a required form to be completed or submitted with the QSA. The contractor shall include with the variance analysis any corrective actions that are planned or implemented. This process will allow the QSA to be the MR operations tool for analysis and reporting of variances by contractors, while the Variance Analysis Report (VAR) in CAFM II will be a contractor budget function. Contractor MR management shall review the budget VAR and add or expound upon the explanations provided their by budget staff. Since the PSC's are not responsible for reporting their costs by CAFM code, they are not required to follow the CAFM II reporting and variance elements of the QSA.

However, if there is a variation in workload that will effect the MR Strategy at the PSC or the AC, the PSC shall be sure this is reflected in the QSA.

The contractor shall submit the QSA within 45 calendar days after the end of each quarter during the CMS fiscal year. The deadlines for submitting the QSA are as follows:

First quarter –February 15
Second quarter –May 15
Third quarter –August 15
Fourth quarter –November 15

Contractors shall send the completed QSA to their regional office medical review business function expert(s) at their respective e-mail address(es), and to central office at: MRSTRATEGIES@cms.hhs.gov. The subject line of the e-mail shall begin with the contractor name followed by "QSA" and then the identifying quarter. PSCs shall see Appendix A of the PSC Umbrella SOW for reporting requirements.

7.8.1.1 – Executive Summary

(Rev.174, Issued: 11-17-06, Effective: 10-01-06, Implementation: 10-06-06)

The QSA is an outgrowth of the *MR* Strategy. The executive summary of the QSA shall provide a high-level summation of overall program requirements enacted, and any progress, changes or updates since the last quarterly analysis (or since submission of the *MR* Strategy). Program requirements include things such as program management, continuous quality improvement activities, and the Comprehensive Error Rate Test (CERT) findings. This allows contractors an opportunity to address important projects and CMS requirements that are not captured under the prioritized *MR* problem list and addressed in the Problem Specific Activities, section 7.8.1.3, and to provide additional information on problem specific activities that are not covered under the QSA criteria. For contractor specific error rates, the contractor shall list actions that have already been taken and that are currently in effect, as well as those actions planned for implementation in the future. The contractor shall utilize this analysis tool as the *MR* reporting mechanism for the CERT Error Rate Reduction Plan (ERRP). This section should include the above-mentioned analysis of cost and workload from the quarterly variance report. The quarterly variance report is not required by the PSCs.

7.8.1.2 – Problem Specific Activities

(Rev.174, Issued: 11-17-06, Effective: 10-01-06, Implementation: 10-06-06)

In accordance with the *MR* strategy process (IOM 100-8, chapter1), contractors shall develop a prioritized medical review problem list. The QSA will summarize the activities taken to address each of the problems identified in the *MR* strategy that the contractor focused on during the quarter. For each problem the contractor shall report on the following:

- Problem Description (include problem number as identified in the strategy)
- Probe Reviews
    - Number Identified
    - Number Initiated
    - Number Completed
- Targeted Reviews
    - Number Identified
    - Number Initiated
    - Number Completed

A spreadsheet shall track the progress made on each problem addressed until the problem is resolved. The spreadsheet should not be greater than one page per problem. Refer to the following chart for the recommended spreadsheet format.

CMS
CONTRACTOR MEDICAL REVIEW
FY 2004 *MR* QUARTERLY STRATEGY ANALYSIS

CONTRACTOR NAME/NUMBER: **ANALYZE BY CONTRACTOR SITE**

PROBLEM DESCRIPTION:

Activity	Quarter Ending 12/31/03	Quarter Ending 3/31/04	Quarter Ending 6/30/04	Quarter Ending 9/30/04
	Numeric Data	Numeric Data	Numeric Data	Numeric Data
A. PROBE REVIEWS				
1. Number Identified				
2. Number Initiated				
3. Number Completed				
B. TARGETED REVIEW				
1. Number Identified				
2. Number Initiated				
3. Number Completed				

FINDINGS AND FOLLOW-UP PLANS FOR PROBES SHALL BE REFERENCED IN NARRATIVE.

RESULTS AND FOLLOW-UP PLANS FOR REVIEWS SHALL BE REFERENCED IN NARRATIVE.

7.8.1.2.1 - Problem Specific Activity Definitions

(Rev.174, Issued: 11-17-06, Effective: 10-01-06, Implementation: 10-06-06)

A. Probe Reviews

1. Number Identified: The number of probe reviews cases that have been identified by the contractor through data analysis and earmarked as part of the medical review activities to address the particular medical review problem. A probe review case is a random sample of 20 to 40 claims in the case of a provider-specific problem, or 100 randomly sampled claims for a widespread or service-specific problem (see IOM 100-8, Chapter 3, §14).

2. Number Initiated: The number of probe review cases identified to address the particular medical review problem area for which substantive medical review resources have been deployed. In general, initiation of a probe case is usually the date a request for medical records is sent to the provider(s).

3. Number completed: For the purposes of reporting in the QSA, a probe case is considered completed when the medical review is concluded and corrective actions have been initiated. Examples of corrective action initiation include:

a) *Initial feedback* on the review findings and results have been supplied to the provider along with instructions on how to correct the problems and notification of any other corrective actions to be implemented as a result of the review,

b) Referrals for overpayment collection (as applicable) have been made,

c) Referrals for targeted prepayment medical review (as applicable) have been made,

d) Referrals for follow-up action (as applicable) have been made (e.g., in the case of no prepay review, a referral has been made to the data analysis area for follow-up; or referral for follow-up probe review has been made to the appropriate medical review area),

e) Referrals for quality of care or QIO (as applicable) have been made, and

f) Referrals for any other category of corrective action have been made.

B. Targeted Review

1. Number Identified: The number of providers that have been identified through probe review (or other method) as billing in error for a particular service or services, and referred for placement on targeted medical review as a means of corrective action to address the particular medical review problem area. In the case of more than one service, the range of services must all be part of a general heading of services that can be grouped under the particular medical review problem (e.g., physical medicine &

rehabilitation as a medical review problem area may include a range of services being supplied by a provider such as 97110-97112, 97116, 97140 and 97530).

In addition, targeted medical review could also be directed toward a specific service or group of services that can be included under the general heading of the particular medical review problem, having been validated as a widespread problem through probe review. For example, with physical medicine & rehabilitation as a widespread medical review problem area and the range of services including 97110-97112, 97116, 97140 and 97530, the number of services identified for this problem area would 5.

2. Number Initiated: The number of providers or services identified for placement on targeted medical review to address the particular medical review problem area and for which a screen or suspension of claims has been initiated.

3. Number Completed: For the purposes of reporting in the QSA, a targeted medical review case is considered completed when data analysis shows there is no longer an aberrance in billing patterns, denial rates for claims included in the targeted review are at or below an acceptable threshold, and the screen has been deactivated for the provider or service(s).

7.8.1.3 – Narrative

(Rev.174, Issued: 11-17-06, Effective: 10-01-06, Implementation: 10-06-06)

In a narrative for each problem, the contractor shall *provide feedback* for that particular problem. The narrative will be the mechanism for the contractor to communicate changes in problem priority, rational for variances, or any other item the contractor feels would be beneficial to the problem at hand. The contactor shall include in the narrative any QA initiatives performed during the quarter. In particular, the contractor shall discuss the effectiveness of *interventions* performed. The contractor shall include actions that will continue or begin in the next quarter. In addition, the contractor shall indicate when follow-up activities will occur, and the actions that will be taken. The contactor shall update the analysis after the follow-up is complete and describe the results to provide closure to the problem. Furthermore, the contractor shall indicate whether a LCD was generated or revised during the quarter as it relates to the problem addressed. In addition, this section shall identify those problems being addressed as a result of CERT findings.

Finally, as problems are resolved and closed, the problem list should be evaluated, re-prioritized and a new problem(s) initiated. The contractor shall address the evaluation process and problem selection in the QSA.

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11.1 *- Medical Review (MR)*

(Rev.174, Issued: 11-17-06, Effective: 10-01-06, Implementation: 10-06-06)

Contractors are required to incorporate Activity Based Costing (ABC) in the budget process. ABC is a management reporting system that allows contractors to focus on the costs of the work activities instead of the standard cost centers associated with the traditional cost accounting structure. ABC identifies an all inclusive business process for each activity so that the total costs of the activity are fully visible to the MR business manager. Refer to Medicare Financial Management Manual, www.cms.gov/manuals/106_financial/fin106index.asp chapters 1,2, 5, and 6 for more detailed explanation of ABC.

11.1.1 – MR Overview

(Rev.174, Issued: 11-17-06, Effective: 10-01-06, Implementation: 10-06-06)

This chapter of the PIM lists the requirements contractors must follow when allocating MR Costs, Savings and Workload to the MR activities in CAFM and CROWD. These requirements formerly appeared in MCM, Part 1, 4213; MIM, Part 1, 1213 and the MR Budget and Performance Requirements (BPRs). Contractors must allocate to the MR activity code in CAFM II only the workload and costs associated with MR tasks. Contractors must allocate to the MR line in CROWD only these savings that are generated by MR tasks. For example:

- If a nurse reviewer spends 90% of her time performing prepay complex medical review and 10% of her time performing appeals review at the request of the appeals unit, the contractor must allocate 90% of this nurse's salary/fringes to 21221 and the 10% to the appropriate appeals activity code.

- If a non-clinician medical reviewer spends 80% of his time performing Routine review and 20% of his time performing suspect duplicate reviews, the contractor must allocate 80% of this reviewer's salary/fringes to 21002 and the 20% to the appropriate claims processing activity code.

- If a nurse reviewer spends 70% of her time performing postpay complex review for the purpose of making a coverage determination on a provider who has been selected for targeted PCA review and 30% of her time performing reviews to support the claims processing unit, the contractor should report 70% to Postpay Complex Review 21222 and 30% to the appropriate claims processing activity code.

Refer to chapter 1, section 2 www.cms.gov/manuals/108_pim/pim83c01.asp#Sect2 of this manual for detailed overview of the MR Program. This chapter lists the requirements contractors must follow when allocating MR costs and workload to the MR activities in CAFM II. Contractors will be given a specified maximum budget for MR. Based on this budget the contractor is asked to develop a unique *MR* strategy within their jurisdiction that is consistent with the goal of reducing the error rate. The contractor shall utilize their

targeted budget in its entirety on *MR* activities toward the prevention of waste and abuse to the Medicare program.

11.1.2 –Reporting MR Workload and Cost Information and Documentation in CAFM II

(Rev.174, Issued: 11-17-06, Effective: 10-01-06, Implementation: 10-06-06)

Workload information and associated workload cost information shall be maintained and documented on-site by all MR contractors. Each site shall maintain records of its own workload information and associated workload cost information. Contractors shall be able to provide this information upon request from RO and/or CO. Site-specific workload and cost information shall be reported in the remarks section of CAFM II. With RO consent, this information may be submitted by other means with an indication made in the remarks section of the CAFM II IER report.

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

Contractor's MR workload records shall include workload information captured by the Interim Expenditure Report (IER). Only costs (direct, indirect, overhead) incurred to support MR activities are reported on the MR line. Contractors are responsible for ensuring the accuracy of the information contained in CAFM II. The contractor shall alert the RO (for PSCs, the GTL, *Associate* GTL, and SME) to any software or hardware problems that hinder the contractor's ability to report accurate data in CAFM II. The contractor should cc MROperations@CMS.HHS.gov.

11.1.3 – CAFM II Reporting for MR Activities

(Rev.174, Issued: 11-17-06, Effective: 10-01-06, Implementation: 10-06-06)

Contractors shall report all costs associated with the medical review of claims, e.g., sampling design and execution; claims examination, reviewing medical records and associated documentation; assessing overpayments; and contacting providers to notify them of overpayment assessment decisions. All costs associated with collecting the overpayment shall be allocated to the appropriate overpayment collection CAFM II activity code.

To be counted as medical review workload, all claims reviewed by medical review shall be identified in the *MR* strategy and be the result of a MR edit. If resources allow, a MR clinician may be shared with another functional area, such as *provider outreach and education,* claims processing or appeals, as long as only the percentage of the clinician's time spent on MR activities is identified in the strategy and accounted for in the appropriate functional budget area.

The review of a claim for MR purposes is only counted as medically reviewed once no matter how many times the same claim is reviewed during claims processing. MCS users will be exempt from this requirement until July 5, 2005. Effective July 5, 2005 the MCS system shall be revised to automatically deny duplicates of denied lines. Duplicates of denied lines are defined as newly submitted lines that duplicate a line that a contractor has (a) already denied, (b) medically reviewed, or (c) for which the contractor requested but did not received documentation. Denial of duplicate lines shall not be appealable unless the provider documents that the service was not a duplicate because it was performed more often than indicated in the original line. Use a "Duplicate non-paid" denial message whenever this denial is made.

11.1.3.3 - Data Analysis Cost (Activity Code 21007)

(Rev.174, Issued: 11-17-06, Effective: 10-01-06, Implementation: 10-06-06)

Contractors shall report costs associated with data analysis activities associated with discovering program vulnerabilities and developing a *MR* prioritized problem list (IOM Pub 100-8, ch. 1) in CAFM II Activity Code 21007. However, analysis of the data to develop and deliver *educational* interventions shall *not* be reported in an *MR* activity code. In addition, data analysis associated with benefit integrity and law enforcement support shall not be reported here. There is no claims workload to be reported for this activity.

11.1.3.6 – MR Program Management Costs (Activity Code 21207)

(Rev.174, Issued: 11-17-06, Effective: 10-01-06, Implementation: 10-06-06)

The MR Program Management encompasses managerial responsibilities inherent in managing the *MR program*, including: development, modification, and periodic reporting of *MR strategy* 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* 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 shifts in workload focus when indicated;
- Implement MR instructions from regional and/or central office;
- Educate staff on MR program, new CMS instructions, and quality assurance findings (this is different from the internal training of MR staff to perform MR activities); and,
- Support service for PSC performing MR activities other than for the CERT contractor.

11.1.4 - MIP Comprehensive Error Rate Testing (CERT) Support

(Rev.174, Issued: 11-17-06, Effective: 10-01-06, Implementation: 10-06-06)

Beginning in FY 2005, CMS will provide funding earmarked for the AC to support the CERT contractor. This funding will be a "reverse auction" funding system as is found in the MR program. The CERT Support funding is over-and-above the level of funding provided to perform the MR activities listed above. Contractors are not required to develop a MIP CERT Support strategy. Contractors shall not include MIP CERT Support work in their MR strategies. Contractors shall not shift additional funds from *MR* activities to this line.

In addition to satisfying all requirements contained here, contractors shall carry out all CERT Support activities identified in IOM Pub.100-8, ch.12 and all relevant MIP CERT Support One Time Notifications.

13.9 - Provider Education Regarding LCDs

(Rev.174, Issued: 11-17-06, Effective: 10-01-06, Implementation: 10-06-06)

Contractors shall educate the provider community on new or significantly revised LCDs (e.g., training sessions, speaking at society meetings or writing articles in the society's newsletter). *This function shall be charged to provider outreach and education (POE). Inquiries of a clinical nature, such as the rationale behind coverage of certain items or services, shall be handled within medical review (MR), the department responsible for the development of the LCD.*

Carriers are required to publish DMERC summary policies, and other pertinent information supplied by DMERCs, as requested, as part of regular bulletin distributions.