CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 262	Date: July 1, 2008
	Change Request 5644

This transmittal rescinds and replaces Transmittal 252, Change Request 5644, and dated April 11, 2008. Minor changes were made in the Business Requirements in the Background section and the implementation dates were changed to reflect that the CR will be implemented over two releases. All other information remains the same.

SUBJECT: Flagging Health Insurance Claim Numbers (HICN) in the Medicare Carrier System (MCS) for Pre-Payment Review/Audit.

I. SUMMARY OF CHANGES: This CR requires that MCS develop and implement edits/audits that will allow suspension of a claim for a Medi-Medi beneficiary and provider ID combination. Currently, MCS cannot flag the beneficiaries CMS wants to review. CMS wishes to have the MCS maintainer add a process to identify dually eligible beneficiaries that receive services from a user specified provider.

NEW / REVISED MATERIAL
EFFECTIVE DATE: JULY 1, 2008
IMPLEMENTATION DATE: JULY 7, 2008

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	4/4.3/Medical Review for Benefit integrity Purposes

III. FUNDING:

SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):
The Medicare administrative contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

The other box should be marked, however, E-chimp will not allow me to make the change while the CR is in the approval process.

IV. ATTACHMENTS:

Manual Instruction
Recurring Update Notification

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

Attachment – Recurring Update Notification

Pub. 100-08	Transmittal: 262	Date: July 1, 2008	Change Request 5644

This transmittal rescinds and replaces Transmittal 252, Change Request 5644, and dated April 11, 2008. Minor changes were made in the Business Requirements in the Background section and the implementation dates were changed to reflect that the CR will be implemented over two releases. All other information remains the same.

SUBJECT: Flagging Health Insurance Claim Numbers (HICN) in the Medicare Carrier System (MCS) for Pre-Payment Review/Audit

This change request (CR) shall be implemented over the April and July 2008 releases. The design and analysis phases for this CR shall be implemented with the April 2008 release and the coding, testing and implementation phases shall be implemented with the July 2008 release.

Effective Date: July 1, 2008
Implementation Date: July 7, 2008

I. GENERAL INFORMATION

A. Background: Following the strategy of close coordination with Program Integrity Group (PIG) partners (including program safeguard contractors (PSCs), affiliated contractors (ACs)/Medicare administrative contractors (MACs) and law enforcement agencies), PSCs sometimes need to ask Medicare contractors to create edits/audits that target a specific HICN or a large number of HICNs for pre-payment review. Further, Medicare contractors need the capability to develop edits/audits that target a large volume of HICNs for pre-payment review. Those capabilities will allow all Centers for Medicare & Medicaid Services (CMS) partners to share compromised HICNs more easily.

In this regard, CMS has found that, of the providers that bill using compromised HICNs, 90 percent bill for dual eligibles, and 90 percent of providers billing for compromised HICNs frequently bill for new dual eligibles each time they bill. Therefore, CMS wishes to put beneficiary/provider edits/audits in a special class of edits/audits and to have the capability to easily include large numbers of HICNs/provider numbers in the edits/audits. Moreover, CMS wishes to be able to send an electronic table containing the HICNs/provider numbers to an AC/MAC and have ACs/MACs load the HICNs/provider numbers. The HICNs/provider numbers in the table will mainly be based on the beneficiaries' dual eligible status.

In addition, CMS wishes to create MCS edits/audits that will automatically deny (about 90 percent of the edits) or suspend (about 10 percent of the edits) claims that meet the edit/audit criteria. The PSC or AC/MAC may supply a list of HICNs/ provider numbers that MCS edits/audits can use to deny/suspend lines.

This change request (CR) requires that MCS develop and implement edits/audits that will allow denial/suspension of a claim for a beneficiary and provider ID combination. Currently, MCS cannot flag the beneficiaries CMS wants to review. CMS wishes to have the MCS maintainer add a process to identify beneficiaries that receive services from a user (usually a PSC) specified provider.

B. Policy: The Program Integrity Manual (PIM), Pub. 100-08, reflects the principles, values, and priorities for the Medicare Integrity Program (MIP). The primary principle of Program Integrity (PI) is to pay claims correctly. In order to meet that goal, PSCs and ACs/MACs must ensure that they pay the right amount for covered and correctly coded services that legitimate providers render to eligible beneficiaries. The CMS follows four parallel strategies in meeting this goal: 1) preventing fraud through detection, effective enrollment, and education of providers and beneficiaries, 2) early detection through medical review and data analysis, 3) close coordination with partners, including PSCs, ACs/MACs, and law enforcement agencies, and 4) fair and firm enforcement policies. Use of the edits specified in this CR is required by Pub. 100-08, chapter 4.

II. BUSINESS REQUIREMENTS

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5644.1	The MCS shared system maintainer shall develop an MCS shared system module that will allow carriers to deny or suspend claims based on a combination of HICN, Provider ID, service start date, and service end date.								X			
5644.1.1	The module developed for 5644.1 shall search on any combination of HICN, provider ID, and service dates including blank HICN, blank provider ID and blank service dates.								X			
5644.1.2	The module developed for 5644.1 shall search all provider types (i.e., billing, rendering, facility, and referring).								X			
5644.1.3	If service end date is blank and there is a service start date, the module developed for 5644.1 shall use a service date criteria of "on or after the start date."								X			
5644.1.4	The module developed for 5644.1 shall allow an HICN, provider ID, or service dates to occur in more than one set of criteria used during a processing cycle.								X			
5644.1.5	The module developed for 5644.1 shall allow the contractor to specify whether the module will deny or suspend for each edit by changing the value in item 6 of the CMS supplied file described in requirement 5644.3.1.								X			
5644.1.6	The module developed for 5644.1 shall update at								X			

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	least weekly the PIN associations based on updates to the NPI crosswalk.											
5644.1.7	The module developed for 5644.1 shall not affect Audit 345.								X			
5644.2	The module developed for 5644.1 shall use a look up table that has as its source a file that CMS supplies to identify the information included in the denial/suspension criteria implemented in requirement 5644.1.								X			
5644.2.1	The CMS shall transmit the lookup table through Network Data Mover (NDM). **NOTE:** There will only be one update file per update; it will be a full replacement; and it will be the same for all contractors.											CMS
5644.3	The module developed in requirement 5644.1 shall allow the contractor data center to load the table developed in requirement 5644.2 from an electronic file.								X			
5644.3.1	The lines in the CMS supplied file shall be in the following format: **FIELD 1** DESCRIPTION: HICN START: 1 END: 12 LENGTH: 12 TYPE: ALPHANUMERIC VERIFICATION: MUST BE NO MORE THAN 12 CHARACTERS OR BLANK REQUIRED: YES, IF PROVIDER NUMBER IS BLANK **FIELD 2** DESCRIPTION: PROVIDER NUMBER TYPE – THE TYPE OF PROVIDER NUMBER IN FIELD 3. START: 13 END: 13											CMS

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	LENGTH: 1 TYPE: ALPHANUMERIC VERIFICATION: MUST BE A "1" (PIN) OR A "2" (NPI) OR BLANK. REQUIRED: YES, IF HICN IS BLANK **FIELD 3** DESCRIPTION: PROVIDER NUMBER START: 14 END: 33 LENGTH: 20 TYPE: ALPHANUMERIC VERIFICATION: MUST BE A VALID NPI OR PIN OR BLANK. IF THE PROVIDER NUMBER IS A PIN, THE FIRST FIVE POSITIONS MUST BE CONTRACTOR NUMBER. LEFT JUSTIFY THE PROVIDER NUMBER REQUIRED: YES, IF HICN IS BLANK **FIELD 4** DESCRIPTION: SERVICE START DATE START: 34 END: 41 LENGTH: 8 TYPE: NUMERIC IN CCYYMMDD FORMAT VERIFICATION: MUST BE A VALID DATE OR BLANK REQUIRED: YES IF THERE IS AN END DATE **FIELD 5** DESCRIPTION: SERVICE END DATE START: 42 END: 49 LENGTH: 8 TYPE: NUMERIC IN CCYYMMDD FORMAT VERIFICATION: MUST BE A VALID											

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	DATE REQUIRED: NO **FIELD 6** DESCRIPTION: ACTION SHARED SYSTEM SHOULD TAKE 1. DENY CLAIM 2. SUSPEND CLAIM 3. PERMENTANLY DELETE CRITERIA START: 50 END: 50 LENGTH: 1 TYPE: NUMERIC VERIFICATION: MUST BE A NUMBER BETWEEN 1 AND 3 REQUIRED: YES											
5644.3.1.2	The module developed for 5644.1 shall allow the same HICN, provider ID, or service dates that may occur multiple times in the file.								X			
5644.3.1.3	The module developed for 5644.1 shall require an HICN, a provider ID, or both an HICN and a provider ID to be in each criterion in the file.								X			
5644.3.1.4	The maintainer shall include in the module developed for 5644.1 an online screen that the contractor can use to view, update, add, or delete individual criterion in the file.								X			
5644.3.1.5	The CMS shall send the file on an as needed basis with 60 days advance notice via a change request.											CMS
5644.3.1.6	Contractor data centers shall be responsible for loading the file containing criteria.											Contractor Data Centers
5644.4	Data centers shall insure the module developed in requirements 5644.1 through 5644.3 is installed in time for carriers to begin operating the module by the implementation date of this CR.	X			X							Contractor Data Centers
5644.5	Contractors shall insure that the module developed in requirements 5644.1 through 5644.3 is installed in time to begin operating the module by the implementation date of this CR.	X			X							

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5644.5.1	The Railroad Retirement Board carrier shall not be subject to this requirement.				X							
5644.6	Contractors shall implement the files described in 5644.3 within 60 days of the date that the file becomes available for NDM.	X			X							
5644.7	The CR accompanying the list of criteria will provide instructions for review of claim lines that the module suspends, which criteria should suspend claims, and which criteria should deny claims. The CMS supplied file describe in requirement 5644.3.1 will contain an indicator of the action the system should take in field 6.	X			X							PSCs
5644.7.1	The CR will specify which contractor component shall review suspended claims.											CMS
5644.8	Contractors shall report workload and costs for this CR in CAFM II, activity code 23201.	X			X							
5644.8.1	The MCS maintainer shall develop standard reports to support CAFM II reporting.								X			
5644.9	Contractors shall use Reason Code: M79: Missing/incomplete/ invalid charge. Note: (Modified 2/28/03) Claim Adjustment Reason Code: A1: Claim/service denied. Remark code: PR Patient Responsibility MSN: 21.6 - This item or service is not covered when performed, referred or ordered by this provider.	X			X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)							
		A/	DM	FI	CA	DM	RH	Shared-System Maintainers	OTHER

								FISS	MCS	VMS	CWF	
	None.											

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
5644.1	The maintainer should create one edit process for denials and one edit process for suspensions. Separate edits for each possible combination of criteria are not needed.
5644.1	Prioritization of edits is not needed. All edits for this CR should have equal priority relative to which denies a line first or last.

B. For all other recommendations and supporting information, use this space:
NA

V. CONTACTS

Pre-Implementation Contact(s): John Stewart (410) 786-1189 john.stewart@cms.hhs.gov
Post-Implementation Contact(s): John Stewart (410) 786-1189 john.stewart@cms.hhs.gov

VI. FUNDING

A. ***For Fiscal Intermediaries, Carriers, and the Durable Medical Equipment Regional Carrier (DMERC)***

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

B. ***For Medicare Administrative Contractors (MAC)***

The contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

4.3 – Medical Review for Benefit Integrity Purposes

(Rev. 262; Issued: 07-01-08; Effective Date: 07-01-08; Implementation Date: 07-07-08)

As stated in PIM, chapter 1, section 1.1, 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; 3) place emphasis on reducing the paid claims error rate by notifying the individual billing entities (i.e., providers, suppliers, or other approved clinicians) of medical review findings and making appropriate referrals to provider outreach and education (POE); and 4) collaborate with other internal components and external entities to ensure correct claims payment, and to address situations of potential fraud, waste, and abuse.

The statutory authority for the MR program includes sections 1812, 1816, 1832, 1833(e), 1842, 1842(a)(2)(B), 1861, 1862(a), 1862(a)(1), 1861, and 1874 of the Social Security Act (the Act). In addition, the regulatory authority for the MR program rests in 42 CFR 421.100 for intermediaries and 42 CFR 421.200 for carriers. Refer to PIM, chapter 3, for detailed information about the statutory and regulatory authorities.

The focus of MR program is to reduce the error rate through medical review and provider notification and feedback, whereas medical review for BI purposes focuses on addressing situations of potential fraud, waste and abuse.

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. The contractor's ability to make use of available data and apply innovative analytical methodologies is critical to the success of both MR and MR for BI purposes. See PIM, chapter 2 in its entirety for MR and BI data analysis requirements.

The PSC and the ZPIC BI units and the DME PSC, AC, and A/B MAC MR units shall have ongoing discussions and close working relationships regarding situations identified that may be signs of potential fraud. Intermediaries and A/B MACs shall also include the cost report audit unit in the ongoing discussions. AC and A/B MAC medical review (MR) staff shall coordinate and communicate with their associated PSC and ZPIC BI units to ensure coordination of efforts, to prevent inappropriate duplication of review activities, and to assure contacts made by the AC or MAC are not in conflict with benefit integrity related activities.

A. Referrals from the Medical Review Unit to the Benefit Integrity Unit

If a provider appears to have knowingly and intentionally furnished services that are not covered, or filed claims for services not furnished as billed, or made any false statement

on the claim or supporting documentation to receive payment, the DME PSC, AC, or MAC MR unit personnel shall discuss this with the PSC and ZPIC BI unit. If the PSC and the ZPIC BI unit agrees that there is potential fraud, the MR unit shall then make a referral to the PSC or ZPIC BI unit for investigation. Provider documentation that shows a pattern of repeated misconduct or conduct that is clearly abusive or potentially fraudulent despite provider education and direct contact with the provider to explain identified errors shall be referred to the PSC or ZPIC BI unit.

B. Referrals from the Benefit Integrity Unit to the Medical Review Unit and Other Units

The PSC and the ZPIC BI units are also responsible for preventing and minimizing the opportunity for fraud. The PSC and the ZPIC BI units shall identify procedures that may make Medicare vulnerable to potential fraud and take appropriate action.

The PSC and the ZPIC BI unit may request the AC or A/B MAC to install a prepayment edit or auto-denial edit.

The CMS has implemented a recurring edit module in the carrier processing system to allow PSCs and/or CMS to monitor specific beneficiary and provider numbers when PSCs or CMS have discovered problems with the use of that beneficiary and provider numbers. The ACs/MACs and PSCs shall comply with requests from PSCs and/or CMS to implement those edits. The ACs/MACs shall implement parameters for those edits/audits within 60 days of when the file containing the parameters becomes available for NDM. The edits/audits will be updated via Recurring Update Notification.

The PSC and the ZPIC shall work with its own nurses to perform MR for BI reviews.

C. Benefit Integrity/Medical Review Determinations

When MR staff are reviewing a medical record for MR purposes, their focus is on making a coverage and/or coding determination. However, when PSC or ZPIC staff are performing BI-directed medical review, their focus may be different (e.g., looking for possible falsification). The PIM, chapter 3, §§3.4-3.4.3 outlines the procedures to be followed by both MR and MR for BI staff to make coverage and coding determinations.

1. The PSC and the ZPIC shall maintain current references to support medical review determinations, including but not limited to:

- Code of Federal Regulations;
- CMS Internet Only Manuals (IOMs);
- Local coverage determinations (LCDs) and/or local medical review policies (LMRPs) from the affiliated contractor (AC) or MAC;
- Internal review guidelines (sometimes defined as desktop procedures); and

- The review staff shall be familiar with the above references and able to track requirements in the internal review guidelines back to the statute or manual.

2. The PSC and the ZPIC shall have specific review parameters and guidelines established for the identified claims. Each claim shall be evaluated using the same review guidelines. The claim and the medical record shall be linked by identification of patient name, HIC number, diagnosis, ICN, and procedure. The PSC and the ZPIC shall have access to the information contained in the provider tracking systems from medical review for comparison to PSC and ZPIC findings. The information on the tracking systems should be used for comparison to PSC and ZPIC findings. The PSC shall also consider that the medical review department may have established internal guidelines. (See PIM chapter 3, §3.4.4.)

3. The PSC and the ZPIC shall evaluate if the provider specialty is reasonable for the procedure(s) being reviewed. As examples, one would not expect to see chiropractors billing for cardiac care, podiatrists for dermatological procedures, and ophthalmologists for foot care.

4. The PSC and the ZPIC shall evaluate\determine if there is evidence in the medical record that the service submitted was actually provided and if so, if the service was medically reasonable and necessary. The PSC and the ZPIC shall also verify diagnosis and match to age, gender, and procedure.

5. The PSC and the ZPIC shall determine if patterns and/or trends exist in the medical record which may indicate potential fraud, waste or abuse. Examples include, but are not limited to:

- The medical records tend to have obvious or nearly identical documentation;

- In reviews that cover a sequence of codes (Evaluation & Management codes, therapies, radiology, etc.), there may be evidence of a trend to use the high ends codes more frequently than would be expected; and

- In a provider review, there may be a pattern of billing more hours of care than would normally be expected on a given workday.

6. The PSC and the ZPIC shall evaluate the medical record for evidence of alterations including, but not limited to: obliterated sections, missing pages, inserted pages, white out, and excessive late entries.

7. The PSC and the ZPIC shall document errors found and communicate these to the provider in a written format when the provider review does not find evidence of potential fraud. A referral may be made to the POE staff at the AC or MAC for additional provider education and follow-up, if appropriate.

8. The PSC and the ZPIC shall downcode or deny, in part or in whole, depending upon the service under review when medical records do not support services billed by the provider.

9. The PSC and the ZPIC shall thoroughly document the rationale utilized to make the medical review decision.

D. Quality Assurance

Quality assurance activities shall ensure that each element is being performed consistently and accurately throughout the PSC's and the ZPIC MR for BI program. In addition, the PSC and the ZPIC 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.

1. The PSC and the ZPIC shall assess the need for internal training on changes or new instructions (through minutes, agendas, sign-in sheets, etc.) and confirm with staff that they have participated in training as appropriate. The PSC and the ZPIC staff shall have the ability to request training on specific issues.

2. The PSC and the ZPIC shall evaluate internal mechanisms used to determine whether staff members have correctly interpreted the training (training evaluation forms, staff assessments) and demonstrated the ability to implement the instruction (internal quality assessment processes).

3. The PSC and the ZPIC shall have an objective process to assign staff to review projects, ensuring that the correct level of expertise is available. For example, situations dealing with therapy issues may include review by an appropriate therapist or use of a therapist as a consultant to develop internal guidelines. Situations with complicated or questionable medical issues, or where no policy exists, may require a physician consultant (medical director or outside consultant).

4. The PSC and the ZPIC shall develop a system to address how it will monitor and maintain accuracy in decision-making (inter-reviewer reliability) as referenced in PIM, chapter 1, §1.2.3.4.

5. When the PSC and the ZPIC evaluation results identify the need for prepayment edit placement at the AC or A/B MAC, the PSC and the ZPIC shall have a system in place to evaluate the effectiveness of those edits on an ongoing basis as development continues.