CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-08 Medicare Program Integrity	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 179	**Date: DECEMBER 15, 2006**
	Change Request 5252

Subject: Revised Medical Review Timeliness and Reopening Requirements for Medical Review

I. SUMMARY OF CHANGES: Changes MR timeliness requirement to say that the MR department has 60 days to review a claim, make a decision, and either enter the decision into the claims processing system (prepay review) OR mail notification of decision to the provider (postpay review). Also instructs on MR reopening of claims denied due to no response to ADR request when forwarded by appeals.

New / Revised Material
Effective Date: November 29, 2006
Implementation Date: On or before January 16, 2007

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-*Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
R	Ch. 3/3.6.2/Location of Postpayment Review
R	Ch. 3/3.4.1.4/Handling Late Documentation
R	Ch. 3/3.4.1.3/Completing Complex Reviews
R	Ch. 3/3.4.1.2/Additional Documentation Requests (ADR) During Prepayment of Postpayment Review
N	Ch. 3/3.4.1.5/Re-openings of claims Denied Due to Failure to Submit Necessary Medical Documentation (remittance advice code N102 or 56900)
R	Ch. 3/Table of contents

III. FUNDING:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2007 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: 179	Date: December 15, 2006	Change Request:5252

SUBJECT: Medical Review Timeliness and Reopening Requirements

Effective Date: November 29, 2006

Implementation Date: On or before January 16, 2007

I. GENERAL INFORMATION

A. Background: This change in the 60-day timeliness requirement for medical review (MR) clarifies MR departments must make a determination and forward the claim for final adjudication within 60 days of receipt of requested documentation at the contractor. This requirement mandates that a medical review determination is made and entered into the FISS, MCS, or VMS system within 60 days, allowing the claim to move through the claims processing system at that time. Also, this CR addresses reopening of claims denied with Remittance Advice Code N102/56900 ("This claim has been denied without reviewing the medical record because the requested records were not received or were not received timely.") when the decision is appealed within 120 days of the denial.

B. Policy: For ADR responses that are received within the timeframe (or extended time frame), contractors must make a medical review determination and *either* enter the decision and reason codes into the FISS, MCS, or VMS system (prepay review) *or* mail the notification letter to the provider (postpay review) within 60 days of receiving requested documentation at the contractor.

When a claim is denied by MR with remittance advice code N102 or 56900 ("This claim has been denied without reviewing the medical record because the requested records were not received or were not received timely.") and the denial is appealed, the appeals department will send the claim to the MR department for reopening under certain conditions, listed in CMS Pub. IOM 100-04, chapter 34, §10.3. MR shall conduct this reopening, beginning the 60-day medical review time period when the reopening request and requested documentation are received in the MR department.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

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	PSCs who perform Medical Review work
5252.1	The contractors shall make a medical review determination and enter the decision and reason codes into the FISS, MCS, or VMS system	X		X	X		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	PSCs who perform Medical Review work
	within 60 days of receiving requested documentation in the contractor's mailroom, for prepayment medical review.											
5252.2	The contractor shall make a medical review determination and mail the notification letter to the provider within 60 days of receiving requested documentation in the contractor's mailroom, for postpayment medical review.	X		X	X		X					X
5252.3	For postpayment review, contractors shall either: Begin counting an independent 60-day time period for review of each medical record when the record is received in the contractor's mailroom OR Wait until all requested medical records are received in the contractor's mailroom to begin counting the 60-day time period.	X		X	X		X					X
5252.4	Contractors shall stop counting the 60-day time period for medical review for any claims associated with a case that is referred to the PSC or PSC BI unit for a benefit integrity investigation on the date the referral is made.	X		X	X		X					X
5252.5	Contractors shall resume counting the 60-day time period for any claims referred for a benefit integrity investigation on the date that requested input is received from the PSC or the contractor is notified by the PSC that the case has been declined.	X		X	X		X					X
5252.6	The contractor MR department shall reopen a claim denied by MR with	X		X	X		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	PSCs who perform Medical Review work
	remittance advice code N102 or 56900, when forwarded to MR from appeals, in accordance with CMS Pub IOM 100-04, chapter 34, section 10.3.											
5252.6.1	Contractors make a medical review determination on the lines previously denied due to failure to submit requested documentation and do one of the following within 60 days of receipt of the claim and requested documentation in MR: • For claims originally selected for postpay review, issue a new letter containing the revised determination and information required by PIM chapter 3, section 3.6.5; or • For claims originally selected for prepay MR enter the revised MR determination into the FISS, MCS, or VMS system.	X		X	X		X					X
5252.6.2	Contractors who report in CAFM shall report the cost associated with these reopenings in CAFM code 21210			X	X							
5252.7	Contractors shall begin counting the 60-day time period when the reopening request and requested documentation are received in the MR department, when reopening requests forwarded from the appeals department.	X		X	X		X					X
5252.8	The contractor shall deny claims using remittance advice code N102/56900 when no response is received within 45 days after the date of the request (or extension).	X		X	X		X					X
5252.8.1	The contractor shall count these denials as automated review			X	X		X					
5252.9	Contractors who choose to reopen	X		X	X		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	PSCs who perform Medical Review work
	claims after receipt of late documentation in MR, from a provider, within a reasonable number of days shall notify the provider of their intent to reopen, make an MR determination on the lines previously denied due to failure to submit requested documentation, and do one of the following within 60 days of receipt of the requested documentation in the contractor's mailroom: • For claims originally selected for postpay review, issue a new letter containing the revised determination and information required by PIM chapter 3, section 3.6.5; or • For claims originally selected for prepay MR enter the revised MR determination into the FISS, MCS or VMS system.											

III. PROVIDER EDUCATION TABLE

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	
5252	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:
	N/A

B. For all other recommendations and supporting information, use the space below:

V. CONTACTS

Pre-Implementation Contact(s): Kim Spalding (Kimberly.spalding@cms.hhs.gov), or CDR Marie Casey (marie.casey@cms.hhs.gov)

Post-Implementation Contact(s): Regional offices

VI. FUNDING

A. ***For TITLE XVIII Contractors*****, use only one of the following statements:**
No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

B. ***For Medicare Administrative Contractors (MAC)*****, use only one of the following statements:**

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 specified 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.

Medicare Program Integrity Manual

Chapter 3 - Verifying Potential Errors and Taking Corrective Actions

Table of Contents
(Rev. 179, 12-15-06)

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

(Rev. 179, Issued: 12-15-06; Effective: 11-29-06; Implementation: 01-16-07)

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 *or supplier* by issuing an additional documentation request (ADR). Contractors shall 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 shall* not deny other claims related to the documentation of the patient's condition before and after the claim in question unless appropriate consideration *is given* to the actual additional claims and associated documentation.

Contractors *shall* 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 *shall* support the medical necessity of the item(s) or service(s) provided. The treating physician, another clinician or provider, *or supplier* may *supply* this documentation. This documentation may take the form of *clinical* evaluations, *physician evaluations*, *consultations, progress notes,* physician letters, 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 *medical necessity* 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 *post-pay* review, a contractor chooses to send an Additional Documentation Request (ADR) regarding a non-lab targeted service, they *shall* solicit the documentation from the billing provider *or supplier* 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 *or supplier* ADR. Contractors *shall* send ADRs in accordance with the following requirements:

Billing Provider *or Supplier* ADRs

- Contractors who choose to request additional documentation *shall* solicit such information from the billing provider *or supplier* and *shall* notify them that they have 30 days to respond. Contractors have the discretion to grant an extension of the timeframe upon request. The contractor *shall* pend the claim for 45 days. Contractors may cc a third party.
- Contractors have the discretion to issue no more than *two (*2*)* "reminder" notices via letter or phone call prior to the 45th day.
- If information is automatically requested only from the billing provider *or supplier* and no response is received within 45 days after the date of the request (or extension), the contractor *shall* 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). *These claims denials are issued with Remittance Advice Code N102/56900 ("This claim has been denied without reviewing the medical record because the requested records were not received or were not received timely."). These denials* count as automated review. *Refer to PIM chapter 3, section 3.4.5 for definitions and examples of types of prepayment and postpayment review.*
- If information is requested only from the billing provider *or supplier* and the information received fails to support the *medical necessity of the service*, in full or in part, the contractor *shall* deny the claim, in full or in part, using the appropriate denial code (see section *3.*4.2). *Beneficiaries cannot be held liable for these denials unless they received proper liability notification before services were rendered, as detailed in CMS Pub IOM 100-04, chapter 30. These denials* would count as complex review. *Refer to PIM chapter 3, section 3.4.5 for definitions and examples of types of prepayment and postpayment review.*

THIRD PARTY ADRs

A contractor *shall* NOT solicit documentation from a third party unless the contractor first or simultaneously solicits the same information from the billing provider *or supplier*. *Some examples of third parties are a physician's office (e.g. if claim is for lab, x-ray, or Part A service requiring medical documentation), or a hospital (e.g. if claim is for physician's inpatient services),* Beneficiaries are not third parties.

When a contractor solicits documentation from a third party:

- The contractor *shall* notify the third party that they have 30 days to respond and copy the billing provider or *supplier*. Contractors have the discretion to grant extensions of the timeframe upon request.
- For prepay review, the contractor *shall* pend the claim for 45 days. This 45 day time period may run concurrent with the 45 day time period for the billing provider or *supplier* ADR letter;
- Contractors have the discretion to issue no more than *two (*2*)* "reminder" notices via email, letter or phone call prior to the 45th day;
- If information is requested from both the billing provider *or supplier* and a third party and no response is received from either within 45 days after the date of the request (or extension), the contractor *shall* deny the claim, in full or in part, as not reasonable and necessary. *These claims denials are issued with Remittance Advice Code N102/56900 ("This claim has been denied without reviewing the medical record because the requested records were not received or were not received timely."). These denials* would count as automated review.
- If information requested from both the billing provider *or supplier* and a third party and a response is received from one or both, but the information fails to support the *medical necessity of the service*, the contractor *shall* deny the claim, in full or in part, using appropriate denial code (see section 3.4.2). *These denials would count as complex review. Beneficiaries cannot be held liable for these denials unless they received proper liability notification before services were rendered, as detailed in CMS Pub IOM 100-04, chapter 30.*

B. Development of Lab Claims for Additional Documentation

If, during pre- or *post-pay* review, a contractor chooses to send an ADR regarding a targeted **lab** service, *the contractor shall* solicit the documentation from the billing provider *or supplier*, and under certain circumstances, *as listed below*, *shall* also solicit documentation from the ordering provider.

Contractors *shall* send ADRs in accordance with the following requirements:

Billing Or supplier ADRs

- Contractors who choose to request additional documentation *shall* solicit such information from the billing provider *or supplier* and *shall* 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 *shall* 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 *or supplier* by the ordering provider, including any ICD-9 codes or narratives supplied.

- Contractors have the discretion to issue no more than *two (*2*)* "reminder" notices via letter, e-mail, or phone call prior to the 45th day.
- If no response is received from the billing provider or supplier within 45 days after the date of the request (or extension), the contractor *shall* deny the service as not reasonable and necessary. *These claims denials are issued with Remittance Advice Code N102/56900 ("This claim has been denied without reviewing the medical record because the requested records were not received or were not received timely."). These denials* would count as automated review.
- If *the documentation received does not* demonstrate *the medical necessity of* the service, the contractor *shall* deny. *These denials* would count as complex review. *Beneficiaries cannot be held liable for these denials unless they have received proper liability notification before services were rendered, as detailed in CMS Pub IOM 100-04, chapter 30*.
- If the information requested from the billing provider *or supplier* fails to support the coverage or coding of the claim in full or in part, the contractor *shall*:
  - 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 *meets the following provisions*:

1) Solicits information from the billing provider *or supplier*,
2) Finds the ADR response from the billing provider *or supplier* 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 *shall* provide to the ordering provider information sufficient to identify the claim being reviewed.

- The contractor *shall* solicit from the ordering provider *only* those parts of the medical record that are relevant to the specific claim(s) being reviewed. The contractor *shall* notify the ordering provider that they have 30 days to respond and copy the billing provider *or supplier*. Contractors have the discretion to grant extensions of the time frame upon request.
- For prepay review, the contractor *shall* pend the claim for 45 days.
- Contractors have the discretion to issue no more than *two (*2*)* "reminder" notices via email, letter or phone call prior to the 45th day.
- If information is requested from the ordering provider and no response is received within 45 days after the date of the request (or extension), the contractor *shall* deny the claim, in full or in part, as not reasonable and necessary. *These claims denials are issued with Remittance Advice Code N102/56900 ("This claim has been denied without reviewing the medical record because the requested records were not received or were not received timely."). These denials* would 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 *shall* deny the claim, in full or in part, using appropriate denial code (see section 3.4.2). *These denials* would count as a complex review.

C. Psychotherapy Notes

Psychotherapy notes are defined in 45 CFR §164.501 as "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, and any 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 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 *shall* 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. *Beneficiaries cannot be held liable for these denials unless they received proper liability notification before services were rendered, as detailed in CMS Pub IOM 100-04, chapter 30.*

3.4.1.3 – Completing Complex Reviews

(Rev. 179, Issued: 12-15-06; Effective: 11-29-06; Implementation: 01-16-07)

A. Medical Review Timeliness Requirement

When a contractor receives requested documentation associated within 45 days (or allowed extended timeframe- see section 3.4.1.2) in response to an ADR, the contractor must make a medical review determination AND do one of the following within 60 days of receiving documentation:

- *For postpay review, mail the notification letter to the provider or supplier (See PIM Chapter 3, section 3.6.5); or*
- *For prepay review, enter the MR decision into the FISS, MCS, or VMS system.*

B. How to Count the 60-*Day Medical ReviewTime Period*

- For prepay reviews (e.g., prepay probe, regular prepay review) the contractor *shall count day one as the date each new medical record is received in the contractor's mailroom*. Each new medical record received *would have an independent 60-day time period associated with it*.
- For postpay reviews, contractors have the option to either:
    - Begin counting with the receipt of each medical record *in the contractor's mailroom*. Each new medical record received would *have an independent 60-day time period associated with it,* or
    - Wait until all requested medical records are received *in the contractor's mailroom*. *The date on which the last of the requested medical records is received would represent the beginning of the 60-day time period.*

- *For claims associated with any case that is referred to the Program Safeguard Contractor (PSC) or BI unit at the DME PSC for BI investigation, contractors shall stop counting the 60-day time period on the date the referral is made. The 60-day time period will be restarted on the date the contractor receives requested input from the PSC or is notified by the PSC that the case has been declined.*

- *For claims sent to MR for reopening by the contractor appeals department, in accordance with CMS Pub. IOM 100-04, chapter 34, §10.3, begin counting the 60 days from the time the medical records are received in the MR department.*

See PIM, chapter 3, section 3.4.2.C, for description of the notification requirements.

3.4.1.4 - Handling Late Documentation

(Rev. 179, Issued: 12-15-06; Effective: 11-29-06; Implementation: 01-16-07)

There are 2 sets of instructions for handling late documentation received by MR after a denial has been issued due to failure to respond to an ADR. Those instructions are detailed below.

1. If a contractor medical review department receives the requested information *from a provider or supplier* after a denial has been issued but within a reasonable number of days (generally 15 days after the denial date), the contractor may chose to reopen the claim.

    - Contractors who choose to reopen must notify the provider *or supplier* of their intent *to reopen*, make a medical review determination *on the lines previously denied due to failure to submit requested documentation*, and *do one of the following, within 60 days of receiving documentation in the contractor's mailroom (For information on how to count the 60 days, see section 3.4.1.3 B):*

        - *For claims originally selected for postpay review, issue a new letter containing the revised denial reason and the information required by PIM chapter 3, §3.6.5; or*

        - *For claims originally selected for prepay review, enter the revised MR determination into the FISS, MCS, or VMS system, generating a new MSN and remittance advice with the new denial reason and appeals information.*

      The workload, costs, and savings associated with this activity should be allocated to the appropriate MR activity code in CAFM and PIMR (e.g., postpay complex).

- Contractors Who Choose NOT to Reopen -- Contractors who choose not to reopen should not destroy the documentation but instead retain the information (hardcopy or electronic) in a location where it could be accessed by appeals staff and MR staff.

2. *If a contractor medical review department receives the requested information forwarded from the appeals department, in accordance with CMS Pub. IOM 100-04, chapter 34, §10.3, Medical Review shall conduct a reopening, following the processing and reporting instructions in PIM chapter 3, section 3.4.1.5.*

3.4.1.5 - Re-openings of Claims Denied Due to Failure to Submit Necessary Medical Documentation (remittance advice code N102 or 56900)

(Rev. 179, Issued: 12-15-06; Effective: 11-29-06; Implementation: 01-16-07)

In cases where the contractor denies a claim with remittance advice code N102 or 56900 ("This claim has been denied without reviewing the medical record because the requested records were not received or were not received timely.") and the denial is appealed, the appeals department will send the claim to the MR department for reopening under certain conditions, listed in CMS Pub. IOM 100-04, chapter 34, §10.3. The medical review department shall conduct a reopening of claims sent by the appeals department, which meet the criteria described in that section.

In the situation described above, MR shall make a medical review determination on the lines previously denied due to failure to submit requested documentation and do one of the following, within 60 days of receipt of the forwarded claim and requested documentation in the Medical Review department:

- *For claims originally selected for postpay review, issue a new letter containing the revised denial reason and the information required by PIM chapter 3, §3.6.5; or*

- *For claims originally selected for prepay review, enter the revised MR determination into the FISS, MCS, or VMS system, generating a new MSN and remittance advice with the new denial reason and appeals information.*

Contractors who report in CAFM shall report the cost and workload for these re-openings in CAFM-II activity code 21210.

3.6.2 - Location of Postpayment Reviews

(Rev. 179, Issued: 12-15-06; Effective: 11-29-06; Implementation: 01-16-07)

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

Contractors must decide whether to conduct the postpay review at the provider or supplier site or at the contractor site. Considerations in determining whether to conduct a provider or supplier site review are:

- The extent of aberrant patterns identified in their focused review program; (See PIM chapter 3, section 3.2);
- The past failure of a provider or supplier to submit appropriate and timely medical records; and
- Contractor resources.

A. Contractor Site Reviews

The contractor notifies the provider(s) or supplier(s) that they have 30 calendar days from the date of the letter to provide the medical record or other requested documentation. (See PIM Exhibit 7.2 for a sample letter.) Contractors have the discretion to grant an extension of the timeframes upon request.

If the information requested is ***NOT*** received within the *allowed timeframe (or allowed extended time frame)*, the contractor shall review the claims with the information on hand. Contractors *shall make a medical review determination, and mail the notification letter to the provider or supplier within 60 calendar days from the end of the allowed timeframe or allowed extended timeframe.* If the contractor needs more than 60 calendar days, they must request an extension from the RO (for PSCs, the Primary GTL, Associate GTL, and SME).

B. Provider or Supplier Site Reviews

Contractors determine what, if any, advance notification of a scheduled review is given to a provider or supplier. The contractor may give advance notice when a provider or supplier has satellite offices from which medical records will have to be retrieved. When giving advance notice, the contractor shall include an explanation of why the review is being conducted.
The list of claims requiring medical records may be included with the advance notice or at the time of the visit at the discretion of the contractor.

Contractors may conduct team reviews when potential problems exist in multiple areas. The team may consist of MR, audit, BI, State surveyors, provider enrollment or Medicaid staff depending on the issues identified. As a minimum, before conducting provider or supplier site reviews, consult and share information with other internal and external staff as appropriate to determine if there are issues that the reviewers should be aware of or if a team review is needed.

Annually, contractors *shall* instruct providers or suppliers (via bulletin article, Web article, etc.) that any Medicare contractor staff person who visits the provider *or supplier* site *shall* show a photo identification indicating their affiliation with the Medicare contractor. Contractors *shall* provide to all reviewers who participate in provider *or supplier* site reviews a photo identification card indicating the reviewer's affiliation with the Medicare contractor. To perform provider or supplier site reviews, all reviewers *shall* present photo identification cards indicating their affiliation with the Medicare contractor to the provider *or supplier* staff and other reviewers on site.

During provider *or supplier* site reviews, reviewers shall photocopy pertinent medical records when services are denied, when a physician or other medical consultation is needed, or when it appears that records have been altered. Contractors shall retain these records for appeals or BI purposes.

Reviewers shall hold entrance and exit interviews with appropriate provider or supplier staff. A provider or supplier representative can also be present while claims are reviewed. Reviewers *shall* answer any questions the provider or supplier staff may have.

During entrance interviews, reviewers explain the following:

- Scope and purpose of the review;
- Why postpayment review is being conducted;
- The list of claims that require medical records;
- How recumbent of overpayment is made if claims are denied;
- Answer any questions related to the review; and
- Notify the provider or supplier of their rebuttal rights. (See PIM, Chapter 3, Section 3.6.6.)

During exit conferences, the contractor shall discuss the findings of the review. The provider or supplier must be allowed an opportunity to discuss or comment on the claims decisions.