# CMS Medicare Manual System
# Pub. 100-8 Program Integrity

**Department of Health & Human Services (DHHS)**
**Centers for Medicare & Medicaid Services (CMS)**

**Transmittal 39** **Date: MARCH 14, 2003**

**CHANGE REQUEST 2417**

| CHAPTERS | REVISED SECTIONS | NEW SECTIONS | DELETED SECTIONS |
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| 3 | Table of Contents<br>4, 4.1, 4.1.1, 4.1.2, 4.1.4, 4.2, 4.3, 4.6, 5, 6.1, 6.2, 6.4, 6.6, | | 5.3, 5.3.1, 5.3.2, 5.3.3<br>7 |

*Red italicized font identifies new material*

**NEW/REVISED MATERIAL - EFFECTIVE DATE: April 1, 2003**
**IMPLEMENTATION DATE: April 1, 2003**

**Medicare contractors only: These instructions should be implemented within your current operating budget.**

**Chapter 3, Section 4 – Overview of Prepayment and Postpayment Review for MR Purposes** -- Instructs contractors that when MR staff are performing benefit integrity-directed claims review, they should seek direction from the Benefit Integrity (BI) Staff. Clarifies the terms "initial determination" and "revised determinations" in the context of medical review of claims. Clarifies the instances under which contractors must send review notices separate from Additional Documentation Requests (ADRs).

**Chapter 3, Section 4.1 – Determinations Made During Prepayment and Postpayment MR** -- Changes the term "carrier" to "contractor." Changes the term "HCFA" to "CMS." Clarifies that prepayment review for MR purposes may have a different focus than prepayment review for BI purposes. Adds a reference to Exhibit 14 - 14.3. Deletes some unnecessarily prescriptive language from section D.

**Chapter 3, Section 4.1.1 – Documentation Specifications for Areas Selected for Prepayment or Postpayment MR –** Clarifies that for services submitted with an ICD-9 diagnosis code that is missing, incorrect or truncated, contractors must return as unprocessable the service to the provider. Replaces the term "medical impossibility" with "apparent typographical error." Clarifies that claims processed by some Part A systems are already required to contain ICD-9 codes. Corrects a conflict in effective dates by changing April to July. Clarifies how contractors may handle claims containing attachment modifiers that are not targeted for review. Replaces the term "test" with the term "service." Section C is updated to reflect the new requirement in 42 CFR 410.32 that services billed to all contractors (not just carriers) must be ordered by a treating physician.

**Chapter 3, Section 4.1.2, Additional Documentation Requets (ADR) During Prepayment of Postpayment MR –** is revised to delete the requirement that carriers must request additional information before denying or reducing an unassigned claim as not reasonable and necessary. In addition, requirements for submitting additional documentation for laboratory claims are specified. This revision deletes a reference to an expired PM (transmittal AB-00-72); is revised to incorporate a number of changes needed to make the PIM consistent with the laboratory

negotiated rule (42 CFR 410.32). Section B, Development of Lab Claims for Additional Documentation now prohibits contractors from simultaneously soliciting documentation from both the billing and ordering providers, limits the type of information a contractor may request from a billing provider, and requires contractors to deny claims if the billing provider fails to respond timely to an ADR. This revision also requires the billing provider, upon request, to supply to the contractor information sufficient to allow the contractor to identify and contact the ordering provider. If documentation from the billing provider is received but fails to support the medical necessity of the claim, requires the contractor to solicit documentation from the ordering provider. In addition, the contractor must be allowed to "re-pend" the claim for another 45 days while waiting for a response from the ordering provider. This revision clarifies that beneficiaries are not third parties.

**Chapter 3, Section 4.1.4 – Handling Late Documentation** -- Clarifies how these activities should be allocated in CAFM.

**Chapter 3, Section 4.2 – Denials** -- Deletes from section A some inaccurate references to the GA, GY, and GZ modifiers; clarifies in section C that denials for failure to respond timely to an ADR are §1862(a)(1) denials; adds a reference in section E to HCFA Ruling 95-1.

**Chapter 3, Section 4.3 – Documenting That A Claim Should Be Denied** -- Clarifies that contractors must document the basis for the denials they make in the internal claim record (not in Medicare summary notice (MSN) and remittance advice (RA) messages).

**Chapter 3, Section 4.6 – Spreading Workload Evenly --** Clarifies that contractors should attempt to avoid “bunching” workload.

**Chapter 3, Section 4.8 - Review That Involves Utilization Parameters** -- Changes the term "medical impossibility" to "apparent typographical error; “clarifies that denials based on apparent typographical errors, failure of an ADR response to support the coverage or coding of the claim, or no timely response to an ADR letter are not considered utilization parameter denials; deletes a reference to an expired PM (transmittal AB-00-72); clarifies that when overutilization of a lab service is identified and there is not clear policy to serve as the basis for denial, contractors must quickly establish complex review edits that do not involve utilization parameters and make individual claim determinations; directs contractors to attempt to focus lab edits to the greatest extent possible by provider, by diagnosis, by procedure code or in any way OTHER THAN by use of a utilization parameter. This clarification is needed to make the PIM consistent with the lab negotiated rule making (42 CFR 410.32).

**Chapter 3, Section 5 - Prepayment Review of Claims for MR Purposes --** Clarifies that although contractors may not require providers to submit paper claims, they may encourage them to do so.

**Chapter 3, Section 5.1 – Automated Prepayment Review -- C**hanges the term "medical impossibility" to "apparent typographical error."

**Chapter 3, Section 5.3 – Documentation Specifications for Areas Selected for MR --** Deletes this section as the language now appears in chapter 3 section 4.

**Chapter 3, Section 5.3.1 – Laboratory Claims --** Deletes this section as the language now appears in chapter 3 section 4.

**Chapter 3, Section 5.3.2 –Documentation for Non-Physician Claims --** Deletes this section as the language now appears in chapter 3 section 4.

**Chapter 3, Section 5.3.3 – Development of Claims for Additional Documentation --** Deletes this section as the language now appears in chapter 3 section 4.

**Chapter 3, Section 6.1 – Postpayment Review Case Selection** – Clarifies that generally contractors should not perform postpay review of unassigned claims.

**Chapter 3, Section 6.2 – Location of Postpayment Reviews** -- Deletes the instruction that contractors may contact selected beneficiaries.

**Chapter 3, Section 6.3 – Re-adjudication of Claims** -- Deletes the reference to PIM Chapter 3, section 6.2.3.D.

**Chapter 3, Section 6.4 – Calculation of the Correct Payment Amount and Subsequent Over/Underpayment --** Deletes the reference to error validation reviews.

**Chapter 3, Section 6.6 – Provider(s) Rebuttal(s) of Findings** -- Clarifies what can be included in a rebuttal statement. Also, clarifies that contractors should only consider the provider's financial obligation and that concerns about claims determinations should be handled through the appeals process.

# Medicare Program Integrity Manual

## Chapter 3 - Verifying Potential Errors and Taking Corrective Actions

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## 4 – Overview of Prepayment and Postpayment Review for MR Purposes- (Rev. 39, 03-14-03)

The instructions listed in this section (Section 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.*

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 MCM §12001 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; and
- If postpayment, the list of claims that require medical records.

*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.

## 4.1 – Determinations Made During Prepayment and Postpayment MR – (Rev. 39, 03-14-03)

When *contractors* review claims, either on a prepayment or postpayment basis, they may make any or all of the determinations listed below.

Contractors must be able to differentiate the type of determination made to ensure that limitations on liability determinations are made when appropriate.

*When MR staff are reviewing a medical record for MR purposes, their focus is on making a coverage and/or coding determination. However, when MR staff are performing BI-directed review, their focus may be different (e.g., looking for possible falsification, etc.)*

**A -- Coverage Determinations**

A claim may be covered, in full or in part, by a contractor if it meets all the conditions listed in PIM Chapter 13, Section 5.1.

**B -- Limitation of Liability Determinations**

In accordance with §1879 of the Act, contractors first consider coverage determinations based on the absence of a benefit category or based on statutory exclusion. If both these conditions are met, the next consideration should be whether the service was reasonable and necessary. Section 1862(a)(1) of the Act is the authority for denial because a service is not reasonable and necessary. When a claim is denied, in full or in part, because an item or service is not reasonable and necessary, contractors make and document §§1879, 1870, and 1842(l) (limitation of liability) determinations as appropriate. Because these determinations can be appealed, it is important that the rationale for the determination be documented both initially and at each level of appeal.

Limitation of Liability determinations do not apply to denials based on determinations other than reasonable and necessary. *See Exhibits 14 - 14.14.3 for further details.*

**C -- Coding Determinations**

See PIM Chapter 13, Section 5.2 for a description of a coding determination.

**D -- Pricing Determinations for First Time Not Otherwise Classified (NOC) Codes**

In addition, contractor MR staff may assist contractor claims processing staff in making pricing determinations on NOC HCPCS codes. *T*he MR staff will provide information needed to the claims processing staff so that they can price the service in accordance with *CMS* pricing methodologies described in the MCM and MIM. For frequently billed services, to the extent possible, contractors should keep track of these pricing determinations so that for future claims, the claims processing staff can price the claim using established MR pricing guidelines for that service.

## 4.1.1 -- Documentation Specifications for Areas Selected for Prepayment or Postpayment MR - (Rev. 39, 03-14-03)

The contractor may use any information they deem necessary to make a prepayment or postpayment claim review determination. This includes reviewing any documentation submitted with the claim as well as soliciting documentation from the provider or other entity when the contractor deems it necessary and in accordance with PIM Chapter 3, Section 4.1.2.

**A -- Review of Documentation Submitted with the Claim**

If a claim targeted for prepayment or postpayment review (including automated, routine, or complex) contains a modifier indicating that additional documentation is attached or was submitted simultaneously with an electronic claim, the contractor must review the documentation before denying the claim. There are two exceptions to this rule. Contractors may deny without reviewing attached or simultaneously submitted documentation (1) when clear policy serves as the basis for denial, and (2) in instances of medical impossibility (see PIM Chapter 3, §5.1).

**NOTE:** The term "clear policy" means a statute, regulation, NCD, coverage provision in an interpretive manual, or LMRP specifies the circumstances under which a service will always be considered non-covered or incorrectly coded. *Clear policy that will be used as the basis for frequency denials must contain utilization guidelines that the contractor considers acceptable for coverage.*

**B -- Review of Documentation Solicited After Claim Receipt**

The process whereby a contractor requests additional documentation after claim receipt is known as "development." Providers selected for review are responsible for submitting medical records requested of them by the contractor within established timeframes. Development requirements are listed below in Section 4.2.1.

**C -- Requirements That Certain Tests Must Be Ordered By The Treating Physician**

*Effective November 25, 2002,* 42 CFR 410.32(a) requires that when billed to *any contractor*, all diagnostic x-ray *services*, diagnostic laboratory *services*, and other diagnostic *services* must be ordered by the physician who is treating the beneficiary for a specific medical problem and who uses the results in the management of the beneficiary's specific medical problem.

**D -- Diagnosis Requirements**

Section 1833(e) of the Act provides that no payment may be made "under this part unless there has been furnished such information as may be necessary in order to determine the amounts due such provider or other person . . ."Contractors may require information, in accordance with the requirements below whenever they deem necessary to make a determination listed in section 4.1 and thus to determine appropriate payment.

Some provider types are required to submit diagnosis codes on all claims while other provider types are required to submit diagnosis codes only if such information is required by an LMRP.

- **Claims Submitted by Physicians or** §1842(b)(18)(C) of the Act **Practitioners Must Contain Diagnosis Codes**
  Section 1842 (p)(1) of the Act states that each claim submitted by a physician or §1842(b)(18)(C) of the Act practitioner "shall include the appropriate diagnosis code (or codes)…". *For s*ervices from physicians and §1842(b)(18)(C) of the Act practitioners *submitted with an ICD-9 code that is missing, invalid, or truncated, contractors must return the billed service to the provider as unprocessable in accordance with MCM §3005.4(p) or MIM §3605.3.*

- **Claims Submitted By All Other Provider Types Must Contain Diagnosis Codes If Such Codes Are Required By An LMRP (effective 7/1/02)**
  In order to address potential abuse or overutilization, contractors can require that ICD-9 diagnosis codes be submitted with each claim for the targeted service. This information is used in determining whether the services are covered and correctly coded. Effective April 1, 2002, contractors may require ICD-9 diagnosis codes to be submitted by all non-physician billers with every claim for a targeted service only if such a requirement appears in an LMRP for that service. Contractors must educate providers about this requirement beginning no later than January 1, 2002. This outreach should occur via website bulletin articles, etc.

  For individual non-physician providers who are identified due to unusual billing practices, fraud referrals, etc., contractors may also requ*ire* ICD-9 diagnosis codes to support the medical necessity of all or some claims submitted by the targeted entities, even if no LMRP exists requiring such codes.

  For services submitted with *an* ICD-9 diagnosis code *that is missing, incorrect or truncated* as indicated above, contractors *must return the billed service to the provider as unprocessable.*

**E -- Requirements for Lab Claims**

The American Medical Association's (AMA) 1998 edition of the Current Procedural Terminology (CPT) established three new and one revised Organ or Disease Oriented laboratory panels. Since these panels are composed of clinically relevant groupings of automated multichannel tests there is a general presumption of medical necessity. If there is data or reason to suspect abuse of the new panel codes, contractors may review these claims. Should contractors determine the need to develop a LMRP for laboratory panel codes, develop these policies at the panel code level. In some instances of perceived abuse of the new panel codes, you may review the panel and deny component tests on a case-by-case basis or evaluate the need for the component level test.

## 4.1.2 – Additional Documentation Requests (ADR) During Prepayment or Postpayment MR- (Rev. 39, 03-14-03)

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 ensure that all records requested are from the period under review.

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

**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 45$^{th}$ day;

- If information is *automatically* requested **only** from the **billing provide**r 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 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 email, 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 reasonable and necessary. This would count as automated review.

- If information requested from the **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 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;*

- *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;*

- *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 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 must deny the claim, in full or in part, as not reasonable and necessary. This 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 contractor must deny the claim, in full or in part, using appropriate denial code (see Section 4.2). This would count as a complex review.*

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## 4.1.4 - Handling Late Documentation - (Rev. 39, 03-14-03)

**Contractors Who Choose to Reopen** -- If a contractor receives the requested information after a denial has been issued but within a reasonable number of days (generally 15 days after the denial date), the contractor may **reopen** the claim. Contractors who choose to reopen must notify the provider of their intent, make a medical review determination, and notify the provider of the determination within 60 days of receipt of late documentation. The workload, costs, and savings associated with this activity should be allocated to the appropriate **MR** activity code in CAFM and PIMR (i.e., 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.

## 4.2 – Denials - (Rev. 39, 03-14-03)

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 "downcoding").

**A -- Denial Reasons Used for Reviews Conducted for MR or BI Purposes**

Contractors must deny payment on claims either partially (e.g., by downcoding, 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 LMRP;

- 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 downcoding 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 3, §11.2.6.

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.

- **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 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 a 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.

- **Postpay Denial Messages**
  When notifying providers of the results of postpay medical review determinations, the contractor must explain the specific reason each service was considered noncovered 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.

*Effective January 1, 2003, for claims where the contractor makes a denial following complex review, contractors must 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 Part A providers cannot appeal benefit category and statutory exclusion denials, and 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.

## 4.3 - Documenting That A Claim Should Be Denied - (Rev. 39, 03-14-03)

For each claim denied, in full or in part, contractor MR or BI staff must carefully document the basis for the denial *in the internal claim record*. If there are several reasons for denial, *effective 1/1/03, the contractor must* document each basis *in the internal claim record.*

In establishing an overpayment, contractors carefully document claims for services not furnished or not furnished as billed so that the denials are more likely to be sustained upon appeal and judicial review.

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## 4.6 -Spreading Workload Evenly (Rev. 39, 03-14-03)

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

*Contractors should attempt to avoid "bunching" workload.*

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## 4.8 - Review That Involves Utilization Parameters - (Rev. 39, 03-14-03)

**A -- General**

During any type of MR-directed review (prepay or postpay; automated, routine or complex), contractors shall not deny services that exceed utilization parameters unless:

1. **Clear policy** *(see PIM Chapter 3, section 4.1.1)* serves as the basis for the denial;

2. The denial is based on *apparent typographical errors* (e.g., 10,000 blood cultures for the same beneficiary on the same day);

3. The contractor sent an ADR letter and reviewed the ADR response, but the **ADR response failed to support** the coverage or coding of the claim; or

4. **No timely response** is received in response to an ADR letter.

***B -- Automated vs. Complex Review of Non-Lab Claims Involving Utilization Parameters***

Contractors should **always** seek to implement prepayment edits that will prevent payment of services to providers billing egregious amounts and/or to providers with a pattern of billing for services that are not covered. When contractors identify egregious overutilization of a *non-lab service* within the context of their MR Strategy and prioritization of review targets, they must respond timely.

- When overutilization of a *non-lab service* is identified and clear policy serves as the basis for denial, contractors may establish edits to **automatically** deny the services.

- When overutilization of a *non-lab service* is identified and there is **not** clear policy to serve as the basis for denial, contractors must establish **complex** review edits and make individual claim determinations. Contractors must develop the claims for additional documentation in these situations.

If the overutilization problem is determined to be widespread, the contractor should follow the requirements in *progressive corrective action.*

**C -- Automated vs. Complex Review of <u>Lab</u> Claims Involving Utilization Parameters**

*Contractors should **always** seek to implement prepayment edits that will prevent payment of services to providers billing egregious amounts and/or to providers with a pattern of billing for services that are not covered. When contractors identify egregious overutilization of a <u>lab</u> service* within the context of their MR Strategy and prioritization of review targets*, they must respond timely.*

- *When* over*utilization of a <u>lab</u> service* is *identified* and clear policy serves as the basis for denial, *contractors may* establish edits to ***automatically*** *deny the* services.

- *When overutilization of a <u>lab</u> service is identified and there is **not** clear* policy to serve as the basis for denial*, contractors must quickly establish* **manual** *review edits <u>that do not involve utilization parameters</u> and make individual claim determinations. For example, if the problem is limited to a few laboratory providers, the contractor could develop a provider-specific prepayment edit to suspend all of the lab services in question from the problem providers. If the problem is widespread in nature, the contractor could develop a service-specific edit to suspend all of the lab services in question or all of the services in question for a particular diagnosis code or revenue code. Based on data analysis findings within each contractor's jurisdiction, the contractor should attempt to focus the edit to the greatest extent possible by provider, by diagnosis, by procedure code or in any way <u>OTHER THAN by use of a utilization parameter</u>.*

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## 5 – Prepayment Review of Claims For MR Purposes- (Rev. 39, 03-14-03)

The instructions listed in this section (Section 5) apply only to reviews conducted for MR purposes unless otherwise noted.

Contractors may not prohibit providers from submitting electronic claims, even those providers who have been selected for prepayment review. *Contractors may encourage providers who are on 100 percent prepayment MR for a particular service to submit paper claims.*

## 5.1 - Automated Prepayment Review - (Rev. 39, 03-14-03)

When prepayment review is automated, decisions are made at the system level, using available electronic information, without the intervention of contractor personnel. When appropriately implemented, automated review increases efficiency and consistency of decisions. Contractors must implement automated prepayment review whenever appropriate.

Automated review must:

1. Have **clear policy** that serves as the basis for denial;

2. Be based on ***an apparent typographical error*** (e.g., hysterectomy for a male); or

3. Occur when **no timely response** is received in response to an ADR letter.

When a clear policy *(see PIM Chapter 3, Section 4.1.1)* exists or in the case of *an apparent typographical error*, contractors may automatically deny the services without stopping the claim for routine or complex review, **even if documentation is attached**. Reviewers must still make a §1879 of the Act limitation on liability determination, which may require routine review. If additional documentation has been requested for a claim and the information has not been received within 45 days, the denial can be counted as an automated review if there was no human intervention. If human intervention occurs, the denials are counted as routine review.

**NOTE:** The term "clear policy" means a statute*, regulation,* NCD, coverage provision in an interpretive manual, or LMRP specifies the circumstances under which a service will always be considered non-covered or incorrectly coded.

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## 6.1 – Postpayment Review Case Selection (Rev. 39, 03-14-03)

Postpayment reviews are usually targeted to providers, whether individuals or groups, who have demonstrated aberrant billing and/or practice patterns. However, some postpay reviews (e.g., widespread probes) may involve multiple providers.

Contractors must use all available relevant information when selecting postpayment review cases. (See PIM Chapter 3, Section 2 for Verifying Potential Errors and Setting Priorities.)

There are three types of postpayment reviews:

- Error Validation reviews, also known as "probe" reviews (see PIM Chapter 3, Section 2 for more information about probe reviews);
- Statistical Sampling reviews (see *Exhibit 7.4*); and
- Consent Settlement reviews (see PIM, Chapter 3, Section 8.3.3).

**NOTE:** In the process of selecting providers for postpay review, MR staff should review the provider tracking system (PTS) and consult with the BI unit to ensure duplicate efforts are not being undertaken. (See PIM Chapter 3, Section 1.2.)

**A -- Identifying Providers for Error Validation Reviews**

PIM Chapter 3, Section 2 describes the requirements regarding which providers should be selected for error validation (probe) review.

**B -- Identifying Providers for Statistical Sampling Reviews**

The first step in conducting a statistical sampling review is the identification of all services under review from the provider or group of providers for the specified time period (this is termed the "universe") followed by selection of a sample of these claims. Contractors work with their statistical staff and follow all statistical sampling guidelines in PIM Exhibits 7 through 7.7.

Case selection is based on profiling providers who have generated one or more assigned claims during the period under review. *Generally contractors should not perform postpay review of unassigned claims.* Intermediaries use provider numbers and carriers use UPINs for physicians and individual PINs for non-physicians. DMERCs should use the NSC issued supplier numbers. As with physician UPINs and PINs, it may be appropriate to analyze suppliers by their six-digit base number and their 10-digit (six-digit base plus four-digit) location ID number. It may be necessary to conduct sub-studies of locality practices for physicians using their PINs because physicians with one UPIN may have different practices with multiple PINs. Their patterns of practice may vary across different locations (e.g., hospital-based, office-based, SNF-based), especially when physicians designate different specialties for their different PINs.

## 6.2 – Location of Postpayment Reviews (Rev. 39, 03-14-03)

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

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

- The extent of aberrant patterns identified in their focused review program; (See PIM Chapter 3, Section 2.);
- The past failure of a provider to submit appropriate and timely medical records; and
- Contractor resources.

**A -- Contractor Site Reviews**

The contractor notifies the provider(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 7.5 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 45 days, the contractor shall review the claims with the information on hand. Contractors must complete the review and notify the provider in writing of their findings within 60 calendar days from the start of the review, or receipt of medical records, whichever is later. If the contractor needs more than 60 calendar days, they must request an extension from the RO (see PIM Exhibits 7.6 or 7.7).

**B -- Provider Site Reviews**

Contractors determine what, if any, advance notification of a scheduled review is given to a provider. The contractor may give advance notice when a provider has satellite offices from which medical records will have to be retrieved. When giving advance notice, the contractor must 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, fraud, State surveyors, provider enrollment or Medicaid staff depending on the issues identified. As a minimum, before conducting provider 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 must instruct providers (via bulletin article, Web article, etc.) that any Medicare contractor staff person who visits the provider site must show a photo identification indicating their affiliation with the Medicare contractor. Contractors must provide to all reviewers who participate in provider site reviews a photo identification card indicating the reviewer's affiliation with the Medicare contractor. Upon arrival to the provider site, the reviewer must show this photo identification card to the provider staff.

During provider 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 staff. A provider representative can also be present while claims are reviewed. Reviewers must answer any questions the provider 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 of their rebuttal rights. (See PIM, Chapter 3, Section 6.6.)

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

## 6.3 – Re-adjudication of Claims (Rev. 39, 03-14-03)

This section applies to all three types of postpayment reviews (error validation reviews, statistical sampling 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 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 8.) 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 LMRP and any applicable references needed to support individual case determinations. Compliance with these requirements facilitates adherence to the provider notification requirements in PIM Chapter 3, Section 6.5.

## 6.4 – Calculation of the Correct Payment Amount and Subsequent Over/Underpayment (Rev. 39, 03-14-03)

This section applies to *two* types of postpayment reviews (statistical sampling reviews, and consent settlement reviews).

The results of the re-adjudication within the sampling units are used to determine the total overpayment amount for each provider under review. MR must refer to instructions in PIM Exhibits 9, 10, 11 and 12 for projection methodologies based on provider types. Contractors must net out the dollar amount of charges underbilled.

Amounts of the following overpayments are to be included in each provider's estimate of overpayments for the sample:

- Initially paid claims which are denied on re-adjudication, and for which the provisions of §1879 of the Act apply and the provider is liable for the overpayment because: (1) the provider knew or could reasonably have been expected to know that items or services were excluded from coverage, and (2) the provider was not without fault for the overpayment under §1870 of the Act.

- Initially paid claims which are denied on re-adjudication, and for which the provisions of §1879 do not apply, but the provider is liable because it is determined to be not without fault for the overpayment under §1870 of the Act.

- Initially denied claims which are found to be payable on readjudication (in whole or in part). Such claims should be included to reduce the amount of the overpayment sample. For appeal purposes, overpayment estimations will be separately identified for denials in which §1879 of the Act is applied, and denials in which §1879 of the Act does not apply. Where both types of denials occur in the sample, contractors calculate and document separate under/overpayments for the two types of denials. For recovery purposes, however, both denial results are combined.

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## 6.6 – Provider(s) Rebuttal(s) of Findings (Rev. 39, 03-14-03)

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

**A -- Provider(s) Timeframes for Submitting Rebuttal Statements**

Within 15 *calendar* days of notification of the results, each provider may submit a rebuttal statement *including any pertinent information as to why the suspension of payment, offset or recoupment should not be put into effect on the date specified* in accordance with 42 CFR 405.374. The rebuttal statement and any accompanying evidence must be submitted within 15 calendar days from the date of the notification letter described in section 6.5 unless MR or Audit/Reimbursement (A/R) staff find cause otherwise to extend or shorten the time afforded for submission of the statement. *Contractors should only consider the provider's financial obligation. Concerns about claims determinations should be handled through the appeals process.*

**B -- Contractor Review of Rebuttal Statement(s)**

MR and A/R staff should consider all of the evidence *concerning the provider's financial obligation* timely submitted to reach a determination regarding whether recoupment should be delayed. However, recovery of any overpayment will not be delayed beyond the date indicated in the notification letter in order to review and respond to the rebuttal statement even if the principal of the debt is modified after reviewing the rebuttal statement. (See 42 CFR 405.375(a).)

**C -- Cost Report Issues**

Because of the cost report relationship to the overpayment, it is important to note that the projected overpayment recovered from a provider as a result of a postpayment review using statistical sampling is based on the interim payment rate in effect at the time of the review.