Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 607	**Date: August 12, 2015**
	Change Request 9215

Transmittal 600, dated July 2, 2015, is being rescinded and replaced by Transmittal 607, dated August 12, 2015, to add a business requirement to address the insertion of language related to a change in CARC usage by the contractors. All other information remains the same.

SUBJECT: Workload Reporting

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to instruct the Medicare Administrative Contractors (MACs) on how to count no documentation denials of Prepayment Complex Provider and Service Specific Reviews.

EFFECTIVE DATE: August 3, 2015
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: September 3, 2015

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	7/7.2/7.2.2.5/Prepay Complex Provider Specific Review
R	7/7.2/7.2.2.6/Prepay Complex Service Specific Review

III. FUNDING:
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.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

Attachment - Business Requirements

Pub. 100-08	Transmittal: 607	Date: August 12, 2015	Change Request: 9215

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SUBJECT: Workload Reporting

EFFECTIVE DATE: August 3, 2015

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I. GENERAL INFORMATION

A. Background: This CR will provide consistent workload calculating and reporting among the MACs in regards to no documentation received denials.

B. Policy: According to the MACs Statement of Work (SOW), they are required to provide a report of their Medical Review workload. To abide by the SOW and to provide the Centers for Medicare & Medicaid Services with an accurate account of the MAC workload, this CR is providing consistency with the workload reporting.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
9215.1	The contractors shall count no documentation submitted denials as automated review or manual review depending on the method of development.	X	X	X	X					RRB-SMAC, SMRC, ZPICs
9215.2	The contractors shall use Group Code: CO - Contractual Obligation and Claim Adjustment Reason Code (CARC): 50; these are non-covered services because this is not deemed a “medical necessity” by the payer.	X	X	X	X					RRB-SMAC, SMRC, ZPICs

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility

		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Debbie Skinner, 410-786-7480 or Debbie.Skinner@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: 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.

ATTACHMENTS: 0

7.2.2.5 - Prepay Complex Provider Specific Review

(Rev.607, Issued: 08-12-15, Effective: 08-03-15, Implementation: 09-03-15)

Complex medical review requires a licensed medical professional to use clinical review judgment to evaluate medical records. This includes requests for, collection and evaluation of medical records or any other documentation. The review is as a result of vulnerabilities determined by data analysis and identified in the Medical Review strategy. If the requested documentation is not received, the review is not considered complex. The failure of the provider to submit documentation shall result in a denial. *Contractors shall use Group Code: CO - Contractual Obligation and Claim Adjustment Reason Code (CARC): 50; these are non-covered services because this is not deemed a "medical necessity" by the payer.* For the purpose of calculating and reporting MR workload, cost and savings, *contractors shall count these denials as automated review or manual review depending on the method of development.*

7.2.2.6 - Prepay Complex Service Specific Review

Rev.607, Issued: 08-12-15, Effective: 08-03-15, Implementation: 09-03-15)

Complex medical review requires a licensed medical professional to use clinical review judgment to evaluate medical records. Service specific prepay medical review of claims requires that a medical review determination be made before claim payment directed at a certain service. It includes requests for, collection and evaluation of medical records or any other documentation. The review is as a result of vulnerabilities determined by data analysis and identified in the Medical Review strategy. The failure of the provider to submit documentation shall result in a denial. *Contractors shall use Group Code: CO - Contractual Obligation and Claim Adjustment Reason Code (CARC): 50; these are non-covered services because this is not deemed a "medical necessity" by the payer.* For the purpose of calculating and reporting MR workload, cost and savings, *contractors shall count these denials as automated review or manual review depending on the method of development.*