CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2109	**Date: August 10, 2018**
	Change Request 10600

NOTE: This Transmittal is no longer sensitive and is being re-communicated December 19, 2018. The Transmittal Number, date of Transmittal and all other information remains the same. This instruction may now be posted to the Internet.

SUBJECT: Guidance for Medicare Administrative Contractors (MACs) Processing Beneficiary and Family Centered Care (BFCC) Quality Improvement Organizations (QIO) Two-Midnight (2MN) Short Stay Review (SSR) Determinations

I. SUMMARY OF CHANGES: This Change Request (CR) clarifies the MAC follow up actions when they receive the BFCC-QIO Short Stay Review Denial Determinations.

EFFECTIVE DATE: September 11, 2018 - for all other requirements; November 13, 2018 - for provider education
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: September 11, 2018 - for all other requirements; November 13, 2018 - for provider education

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
N/A	N/A

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:

One Time Notification

Attachment - One-Time Notification

Pub. 100-20	Transmittal: 2109	Date: August 10, 2018	Change Request: 10600

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I. GENERAL INFORMATION

A. Background: The Beneficiary and Family Centered Care Quality Improvement Organizations (BFCC-QIOs) conduct post-pay audits, or "Short Stay Reviews (SSR)," per 42 Code of Federal Regulations section 405.980, on a sample of Medicare Part A claims for appropriateness of inpatient admission under the Two Midnight rule for acute care inpatient hospitals, long-term care hospitals, and inpatient psychiatric facilities impacted by FY 2016 Outpatient Prospective Payment System Final Rule, CMS-1633-F, effective January 1, 2016. The 2016 interpretive guidance (https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Downloads/Reviewing-Short-Stay-Hospital-Claims-for-Patient-Status.pdf) states that the BFCC-QIO will conduct patient status reviews for adjudicated claims for dates of admission within the previous 6 months.

The BFCC-QIO develop a detailed results letter which includes individualized, claim-by-claim denial rationales for all providers after the completion of the medial record review and the opportunity for providers to provide additional information for consideration. Upon completion of its review, the BFCC-QIO submits to the Medicare Administrative Contractor (MAC) copies of the final decision letters sent to the provider, listing their SSR determination along with their rationale for any Part A claims denial(s). The BFCC-QIO sends a hard copy of the letter to the MAC via the US postal service.

The SSR denial categories include:

1. Denied as a result of a post-payment review of the medical record; and
2. Denied for non-response to the BFCC-QIO request for medical records (also known as Technical Denial).

The purpose of this Change Request (CR) is to

- Instruct the MACs that the BFCC-QIO SSR denial decisions should be adjusted as an overpayment (a full claim denial) per existing instruction.
- Clarify how the MACs will be notified of the BFCC SSR denial decisions
- Clarify that appeals rights for BFCC-QIO SSR denial determinations are provided through MAC issuance of a demand letter.

B. Policy: This CR provides clarification that SSR denial determinations rendered by the BFCC-QIOs are considered Non-Medicare Secondary Payer (Non-MSP) provider overpayments, therefore adjustments to these claims must follow the existing guidelines outlined in IOM 100-06 Chapter 4 Section 10 titled: Requirements for Collecting Part A and B Non-MSP Provider Overpayments. IOM 100-06, Chapter 4 Section 20 titled: Demand Letters, shall also be followed by the MACs when adjusting SSR determinations. As stated in the Internet Only Manual (IOM), the purpose of the overpayment demand letter is to notify the providers of the existence and amount of an overpayment, and to request repayment. Every demand letter regardless of the cause of the overpayment or the status of the provider, shall meet certain requirements as to form and content. The existing IOM guidance continues, and provides a detailed list of the requirements for the basic overpayment demand letter.

This CR also provides instruction regarding how the MACs are to be notified of the BFCC-QIO's denial determinations. The BFCC-QIO Final Review Results Letter for Short Stay Reviews (BFCC-QIO Final SSR letter) sent to the Provider, and copied to the MAC, is a notification of a post-payment audit denial under Medicare Part A, and therefore, is a non-MSP provider overpayment; the claims identified as "Denied" either [1] as a result of a post-payment review of the medical record or [2] for non-response to the BFCC-QIO request for medical records - become overpayments. The BFCC-QIO Final SSR letter which contains at least one denial will be sent to the MAC via a hard copy letter through the US postal service. Based on this guidance, when the MAC receives the copy of the BFCC-QIO Final SSR letter, they shall identify the denied claims by the beneficiary name, Medicare Identifier (HICN or MBI), BFCC-QIO claim key number and dates of service. The MAC shall adjust the denied claims as an overpayment and issue a demand letter informing the provider of the overpayment as a result of the BFCC-QIO's determination. By instructing that these determinations are to be adjusted as overpayments, this CR clarifies that a 935 demand letter shall be issued by the MAC. The automated generic 935 demand letters will be generated via HIGLAS. As noted above, IOM 100-06, Chapter 4, Section 20 provides a list of demand letter requirements. Included in this list is language that states: The initial demand letter includes language to request the provider or supplier to submit a refund or arrange for immediate recoupment, or file an appeal. Clarification that this established IOM guidance applies to SSR denial determinations will ensure that providers are notified of their appeal rights, and will be allowed the applicable timeframe to appeal.

As detailed above, these SSR denials are considered 935 overpayments. Therefore, MACs are responsible for conducting a redetermination when the request is a result of a BFCC QIO SSR denial. As such, MACs shall follow redeterminations guidance found in IOM 100-04 Chapter 29. When the MAC receives an appeal request for a BFCC QIO SSR technical denial (SSR technical denials are defined as a denial due to a provider's non-response to a BFCC-QIO's request for documentation) which includes the medical records, the MAC must return the claim and medical records to the BFCC-QIO for a reopening. MACs do not have the authority to reopen a QIO-rendered technical denial claims review decision. The MAC should view the reopening as a remedial action taken to revise the previous [binding] decision, thereby allowing the BFCC-QIO the opportunity to perform the SSR as intended, and prior to the non-response denial.

Note: Through the reopening process the BFCC-QIO will: (1) reverse its Technical Denial issued against the provider; (2) process the appeal request as a reopening and conduct the SSR; and (3) then issue a revised SSR final decision letter to the provider, and notify the contractor if the revised decision is a denial.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility			
		A/B MAC	D M E	Shared-System Maintainers	Other

		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
10600.1	When the Contractor receives a BFCC-QIO SSR denial determination via a hard copy letter from the US postal service, the Contractor shall adjust the claim as an overpayment. The Contractors shall perform a post payment claim adjustment within the FISS in order to ensure an accurate claims history in the FISS, and the adjustment shall be completed as 935 eligible, which will kick off the demand within HIGLAS. If this is not included, FISS history would continue to show a paid claim. This will also ensure that upon receipt of a valid SSR appeal, that any recoupments would cease during the first and second levels of appeal. During this process the Contractor must use following FISS adjustment reason codes 1. "Physician order". **Order** for the service billed was **not signed**. Physician certification requirements are in 42 CFR Part 424 subpart B and 42 CFR 412.3. – Adjustment code AD 2. "Physician order". **Order not present** for specific service billed. Physician certification requirements are in 42 CFR Part 424 subpart B and 42 CFR 412.3. – Adjustment code AD 3. "Physician's Order". This claim was denied after review and it was determined that the **physician's order** for the service billed was **not validated**. Physician certification requirements are in 42 CFR Part 424 subpart B and 42 CFR 412.3. IOM: 100-01, Chapter 4, section 10.2 and IOM: 100-01, Chapter 5 section 70 and 70.3. – Adjustment code AD 4. "Physician Intent of 2 midnight stay" **Documentation does not support the physician expected the beneficiary to require care that crosses 2 midnights**. – Adjustment code AM	X								
10600.2	The contractor shall add the following denial codes to FISS. 1. 30801 = provider liable days (use for full or partial denied claim) determines language in the demand letter 2. 30806 = provider liable for fail to submit	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	medical records (full claim reject). The Contractor shall issue a demand letter pursuant to direction in the existing guidelines outlined in the Internet Only Manual (IOM) 100-06, Chapter 4 Section 10 titled: Requirements for Collecting Part A and B Non-MSP Provider Overpayments. IOM 100-06, Chapter 4, Section 20 titled: Demand Letters, shall also be followed by the Contractors when adjusting SSR determinations. The automated generic 935 demand letters will be generated via HIGLAS.									
10600.3	Once the Contractor receives the BFCC-QIO SSR denial Determination they shall issue a 935 written demand letter informing the provider of the overpayment as a result of the BFCC-QIO's determination. The automated generic 935 demand letters will be generated via HIGLAS.	X								
10600.4	The Contractor shall support the exchange of denial information by mutual agreement between the Contractor and the BFCC-QIO which will be outlined in a Joint Operating Agreement (JOA).	X								
10600.5	MACs shall follow instructions on how to proceed after receiving the QIO notification Letter. Contractors shall adjust claims based on the QIO decision in accordance to Publication IOM 100-06 Chapter 4 Section 20 titled: Demand Letters. NOTE: A sample template QIO notification letter is attached. This letter has been recently revised and will be used by the BFCC-QIOs starting in August 2018.	X								
10600.6	Contractors shall send a demand letter in accordance to Publication 100.6, Chapter 3, section 200 and 4, Debt Collections, sections 20.	X								
10600.7	Contractors shall note these denials are considered 935 overpayments and follow the redetermination guidance found in IOM 100-04 Chapter 29 when conducting a redetermination when the request is a result of a BFCC QIO SSR denial.	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
10600.8	The Contractor shall return the claim and medical records to the BFCC-QIO for a reopening, when the Contractor receives an appeal request for a BFCC QIO SSR technical denial which includes the medical records. NOTE: SSR technical denials are defined as a denial due to a provider's non-response to a BFCC-QIO's request for documentation.	X								
10600.9	Contractors shall update their website to address 1) The QIO notification is not a demand letter and 2) when the provider can appeal: Providers can appeal once they received the Initial demand letter due to the QIO notification.	X								
10600.10	The contractor shall not take action on QIO SSR notification letters that may have been received prior to the Implementation date of this CR. Instruction regarding actions the Contractor shall take for these determinations will be forthcoming.	X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
10600.11	MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1, instructions for distributing MLN Connects information to providers, posting the article or a direct link to the article on your website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the "MLN Matters" listserv to get article release notifications, or review them in the MLN Connects weekly newsletter.	X				

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): Malini Krishnan, malini.krishnan@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: 1

«Letter_Date»

«Addressee», «Title»
«Facility»
«Address1»
«Address2»
«City», State «Zip»

«Provider CCN#»

Re: Final Review Results Letter for Short Stay Reviews

Dear «QIO Liason»

<BFCC-QIO name> is the Medicare Beneficiary and Family Centered Care Quality Improvement Organization (QIO) for your area. We are responsible for reviews of medical services provided to Medicare beneficiaries to determine if the services meet medically acceptable standards of care, are medically necessary, and meet Title 42 of the Code of Federal Regulations (CFR) section 412.3 for an inpatient hospital admission.

This review results letter is to share the final Short-Stay Review determination findings for your hospital for inpatient claims for the below patients during the indicated dates of service. We used the patients' medical records to focus on the appropriateness of the inpatient admission claims in accordance with the criteria set forth in Calendar Year (CY) 2016 Outpatient Prospective Payment System (OPPS) Final Rule CMS-1633-FC and the Medicare Benefit Policy Manual, Chapter 1, section 10.2 (rev 234). This final letter includes a listing of activities since our Initial Review Results Letter, our final review findings, a summary of the final results of this review, and redetermination opportunities. Please recall that you were notified about the concern(s) in our Initial Review Results Letter for Short Stay Reviews dated <initial letter date>.

ACTIVITIES SINCE OUR INITIAL REVIEW RESULTS LETTER

_____You did not respond to our Initial Review Results letter by the deadline; therefore, our initial results have been made final. We made a final determination about the utilization concern(s) based solely on the medical record(s). If we did not receive the medical record as requested, the reviewed claim was denied as a Technical Denial.

_____We received and reviewed your hospital's correspondence dated: <Enter date(s) of all correspondence, both in response to the Initial Results Letter and in response to any educational session>.

_____We considered the discussion held on <enter date(s)> during the telephonic educational session with your hospital after the Initial Review Results Letter.

FINDINGS/FEEDBACK

Based upon all of the information received and reviewed, including all medical records submitted, the final results of our review are as follows:

Approved. We agree with the classification of the admission for the following claims:

1. Patient Name: «Patient_Name» HIC Number: «Full HICN»

Date(s) of Service: «From/Thru Dates» QIO Claim Key: «Claim_Key»

2. Patient Name: «Patient_Name» HIC Number: « Full HICN »
Date(s) of Service: «From/Thru Dates» QIO Claim Key: «Claim_Key»

3. Patient Name: «Patient_Name» HIC Number: « Full HICN »
Date(s) of Service: «From/Thru Dates» QIO Claim Key: «Claim_Key»

4. Patient Name: «Patient_Name» HIC Number: « Full HICN »
Date(s) of Service: «From/Thru Dates» QIO Claim Key: «Claim_Key»

5. Patient Name: «Patient_Name» HIC Number: « Full HICN »
Date(s) of Service: «From/Thru Dates» QIO Claim Key: «Claim_Key»

Excluded: We determined that the following claims met criteria for the Two-Midnight Rule exclusion.

6. Patient Name: «Patient_Name» HIC Number: « Full HICN »
Date(s) of Service: «From/Thru Dates» QIO Claim Key: «Claim_Key»

Exclusion Rationale: Provide reasoning behind exclusion.

<<Add additional excluded claims as needed>>

Not Approved because of lack of valid inpatient order. We determined that the following claims did not have a valid inpatient order on the chart. (If the claim was also denied because the claim did not have supporting documentation of a two midnight expectation, that rationale will be reflected in the next paragraph.)

Denied. We determined that the following claims did not have supporting documentation of a two midnight expectation requiring medically necessary hospital services, payable under Part A:

1. Patient Name: «Patient_Name» HIC Number: « Full HICN »
Date(s) of Service: «From/Thru Dates» QIO Claim Key: «Claim_Key»

Case Summary: *(Example: This xx-year-old M/F was admitted for _. He/she had a history of _. The patient received _.)*

Denial Rationale: (Provide reasoning behind denial). Denial Code: (enter appropriate denial code here)

2. Patient Name: «Patient_Name» HIC Number: « Full HICN »
Date(s) of Service: «From/Thru Dates» QIO Claim Key: «Claim_Key»

Case Summary: *(Example: This xx-year-old M/F was admitted for _. He/she had a history of _. The patient received _.)*

Denial Rationale: (Provide reasoning behind denial). Denial Code: (enter appropriate denial code here)

3. Patient Name: «Patient_Name» HIC Number: « Full HICN »
Date(s) of Service: «From/Thru Dates» QIO Claim Key: «Claim_Key»

Case Summary: *(Example: This xx-year-old M/F was admitted for _. He/she had a history of _. The patient received _.)*

Denial Rationale: (Provide reasoning behind denial). Denial Code: (enter appropriate denial code here)

<<Add additional approved/denied claims for larger sample size up to 25 as applicable>>

Here is a summary of systemic patterns identified during the QIO review that, if corrected, could result in approval of future Part A payment or appropriate billing by the hospital for Part B services. <<Describe corrective actions the hospital could take to reduce their billing error rate.>>

FINAL OVERALL RESULTS

The following is a final summary of the claims reviewed with dates of admission from <<Enter Start Date Month/Year>> through <<Enter End Date Month/Year>>. Please note that the number of claims denied includes Technical Denials for non-response to our requests for medical records. The error rate is calculated by dividing the number of claims denied by the number of claims requested.

Here is a summary of systemic patterns identified during the QIO review that if corrected could result in approval for Part A payment or appropriate billing by the hospital for Part B services. <

Reviewed Claims Summary	**Review Results**
#Claims Requested	insert data
#Claims Requested and Excluded from Review (e.g., Inpatient Only List, incorrect discharge status)	insert data
#Claims Reviewed	insert data
#Claims Denied	insert data
Claims Error Rate (CER)	Insert %
Concern Category Rating	Minor/Moderate/Major

OPPORTUNITY TO APPEAL

Note:

We are also notifying the Medicare Administrative Contractor (MAC) of our final determination. This letter with the claim information will be sent to the MAC and payment adjustments will be made. **The MAC will issue a Remittance Advice when your claim is adjusted, and a Demand Letter containing both the information regarding repayment of funds and your formal appeal rights.** The "Total Overpayment Amount to be Demanded" shall be reflected in the demand letter.

If you have any questions concerning this final notice, please contact <<QIO>>, <Attn: Name/Position> at 1-xxx-xxx-xxxx, extension xxxx.

We appreciate your commitment to providing high quality care to your patients and for recognizing and applying the Medicare 2 Midnight Rule policy to inpatient hospital stays.

Sincerely,

<<Signature QIO Medical Director>>

<<Name QIO Medical Director>>

Medical Director, <<QIO>>

cc: «FI/MAC»
<<MAC Name>>
Attention: Short Stay Reviews
«MAC Address1»
«MAC Address2»
«MAC City», MAC State «MAC Zip»
«FAX»

Note (do not include this note in the letter): The BFCC-QIO must identify each denied claim with one of the following denial codes:

a. "Physician order". **Order** for the service billed was **not signed**. Physician certification requirements are in 42 CFR Part 424 subpart B and 42 CFR 412.3. – Adjustment code AD
b. "Physician order". **Order not present** for specific service billed. Physician certification requirements are in 42 CFR Part 424 subpart B and 42 CFR 412.3. – Adjustment code AD
c. "Physician's Order". This claim was denied after review and it was determined that the **physician's order** for the service billed was **not validated**. Physician certification requirements are in 42 CFR Part 424 subpart B and 42 CFR 412.3. IOM: 100-01, Chapter 4, section 10.2 and IOM: 100-01, Chapter 5 section 70 and 70.3. – Adjustment code AD
d. "Physician Intent of 2 midnight stay" **Documentation does not support the physician expected the beneficiary to require care that crosses 2 midnights**. – Adjustment code AM