CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-08 Medicare Program Integrity	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 791	**Date: April 27, 2018**
	Change Request 10505

SUBJECT: Restoring Section 3.2.3 B. and Section 3.2.3 C. to Chapter 3 of Publication (Pub.) 100-08 in the Internet Only Manual (IOM)

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to add sections 3.2.3 B. and 3.2.3 C. to Chapter 3 of Pub. 100-08 in the IOM. This information was erroneously omitted from CR 9809. All other information from CR 9809 remains the same.

EFFECTIVE DATE: May 29, 2018
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: May 29, 2018
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	3/3.2/3.2.3/Requesting Additional Documentation During Prepayment and Postpayment 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: 791	Date: April 27, 2018	Change Request: 10505

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I. GENERAL INFORMATION

A. Background: The July 11, 2017 implementation of CR 9809 erroneously omitted Section 3.2.3.B. (Authority to Collect Medical Documentation (CR4091)) and Section 3.2.3.C. (PWK (Paperwork) Modifier (CR7330)) from Chapter 3 of Pub. 100-08. This CR will re-establish those sections in Chapter 3 of Pub.100-08 in the IOM. Contractors shall be aware that the Centers for Medicare & Medicaid Services (CMS) is re-establishing the sections with this CR.

B. Policy: This CR does not involve any legislative or regulatory policies.

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	
10505.1	Contractors shall be aware that CMS is re-establishing Section 3.2.3 B. (Authority to Collect Medical Documentation (CR 4091)) and Section 3.2.3 C. (PWK (Paperwork) Modifier (CR7330)) that were erroneously omitted in the July 11, 2017 implementation of CR 9809.	X	X	X	X					CERT, RACs, SMRC, UPICs, ZPICs
10505.2	The Contractors' medical review departments shall review unsolicited documentation (i.e., PWK) when the claim suspends for a medical review edit/audit.	X	X	X	X					CERT, RACs, SMRC, UPICs, ZPICs
10505.2.1	Contractors shall not send an Additional Documentation Request (ADR) request for a claim with a PWK modifier until after review of the PWK unsolicited documentation or the waiting days have elapsed	X	X	X	X					CERT, RACs, SMRC, UPICs, ZPICs

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	without receipt of documentation.									
10505.2.2	Contractors shall allow 7 calendar “waiting days” (from the date of receipt of the claim) for additional unsolicited documentation to be submitted or 10 calendar “waiting” days for the unsolicited documentation to be mailed.	X	X	X	X					CERT, RACs, SMRC, UPICs, ZPICs
10505.2.3	Contractors serving island territories shall have the flexibility to adjust "waiting days" as is necessary.	X	X	X	X					CERT, RACs, SMRC, UPICs, ZPICs
10505.2.4	The contractors shall discuss with and get approval from their contracting officer prior to implementation of any adjustments from the core 7/10 "waiting days."	X	X	X	X					CERT, RACs, SMRC, UPICs, ZPICs
10505.2.5	The contractors shall make a determination on the claim within 30 calendar days after the documentation has been received.	X	X	X	X					CERT, RACs, SMRC, UPICs, ZPICs
10505.2.6	The contractors shall request additional documentation using their normal business procedures for ADR that are outlined in Chapter 3 of Pub. 100-08, if they cannot make a determination on the claim after reviewing the unsolicited documentation submitted.	X	X	X	X					CERT, RACs, SMRC, UPICs, 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): Linda O'Hara, 410-786-8347 or linda.ohara@cms.hhs.gov , Atiya Wells, 410-786-6018 or atiya.wells@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

3.2.3 - Requesting Additional Documentation During Prepayment and Postpayment Review

(Rev.791; Issued: 04-27-18; Effective: 05-29-18; Implementation: 05-29-18)

This section applies to MACs, CERT, RACs, and ZPICs/UPICs, as indicated.

A. General

In certain circumstances, the MACs, CERT, RACs, and ZPICs/UPICs may not be able to make a determination on a claim they have chosen for review based upon the information on the claim, its attachments, or the billing history found in claims processing system (if applicable) or the Common Working File (CWF). In those instances, the reviewer shall solicit documentation from the provider or supplier by issuing an additional documentation request (ADR). The term ADR refers to all documentation requests associated with prepayment review and postpayment review. MACs, CERT, RACs, and ZPICs/UPICs have the discretion to collect documentation related to the beneficiary's condition before and after a service in order to get a more complete picture of the beneficiary's clinical condition. The MAC, RAC, and ZPIC/UPIC shall not deny other claims submitted before or after the claim in question unless appropriate consideration is given to the actual additional claims and associated documentation. The CERT contractor shall solicit documentation in those circumstances in accordance with its Statement of Work (SOW).

The term "additional documentation" refers to medical documentation and other documents such as supplier/lab/ambulance notes and includes:

- Clinical evaluations, physician evaluations, consultations, progress notes, physician's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports. This documentation is maintained by the physician and/or provider.

- Supplier/lab/ambulance notes include all documents that are submitted by suppliers, labs, and ambulance companies in support of the claim (e.g., Certificates of Medical Necessity, supplier records of a home assessment for a power wheelchair).

- Other documents include any records needed from a biller in order to conduct a review and reach a conclusion about the claim.

NOTE: Reviewers shall consider documentation in accordance with other sections of this manual.
The MAC and ZPIC/UPIC have the discretion to deny other "related" claims submitted before or after the claim in question, subject to CMS approval as described below. If documentation associated with one claim can be used to validate another claim, those claims may be considered "related." Approved examples of "related" claims that may be denied as "related" are in the following situations:

- When the Part A Inpatient surgical claim is denied as not reasonable and necessary, the MAC may recoup the surgeon's Part B services. For services where the patient's history and physical (H&P), physician progress notes or other hospital record documentation does not support the medical necessity for performing the procedure, postpayment recoupment may occur for the performing physician's Part B service.

- Reserved for future approved "related" claim review situations. The MAC shall report to their BFL and COR prior to initiating denial of "related" claims situations.

The MAC and ZPIC/UPIC shall await CMS approval prior to initiating requested "related" claim(s) review. Upon CMS approval, the MAC shall post the intent to conduct "related" claim review(s) to their Web site within 1 month prior to initiation of the approved "related" claim review(s). The MAC shall inform CMS of the implementation date of the "related" claim(s) review 1 month prior to the implementation date.

If “related” claims are denied automatically, MACs shall count these denials as automated review. If the “related” claims are denied after manual intervention, MACs shall count these denials as non-medical record review.

The RAC shall utilize the review approval process as outlined in their SOW when performing reviews of “related” claims.

The MAC, RAC, and ZPIC/UPIC are not required to request additional documentation for the “related” claims before issuing a denial for the “related” claims.

Contactors shall process appeals of the “related” claim(s) separately.

B. Authority to Collect Medical Documentation

Contractors are authorized to collect medical documentation by the Social Security Act. Section 1833(e) states “No payment shall be made to any provider of services or other person 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 under this part for the period with respect to which the amounts are being paid or for any prior period.” Section 1815(a) states “…no such payments shall be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due such provider under this part for the period with respect to which the amounts are being paid or any prior period.”

The OMB Paperwork Reduction Act collection number for prepayment medical review is 0938-0969. MACs shall use this number on every additional documentation request or any other type of written request for additional documentation for prepayment medical review. It can be in the header, footer or body of the document. CMS suggests the information read “OMB #: 0938-0969” or OMB Control #: 0938-0969.” Postpayment medical review does not require an OMB control number.

C. PWK (Paperwork) Modifier

MAC medical review departments are only required to review unsolicited documentation when the claim suspends for a medical review edit/audit. MACs shall not send an ADR request for a claim with a PWK modifier until after review of the PWK unsolicited documentation or the waiting days have elapsed without receipt of documentation. MACs shall allow 7 calendar “waiting days” (from the date of receipt of the claim) for additional unsolicited documentation to be submitted or 10 calendar “waiting” days for the unsolicited documentation to be mailed. Contractors serving island territories shall have the flexibility to adjust “waiting days” as is necessary. CMS expects that any adjustment from the core 7/10 days will be discussed with and approved by your contracting officer prior to implementation. When the documentation is received, the contractor has 30 calendar days to make a determination on the claim. If the contractor cannot make a determination on the claim after reviewing the unsolicited documentation submitted, they shall request additional documentation using their normal business procedures for ADR that are outlined in Chapter 3 of the Program Integrity Manual.