CMS Manual System

Pub 100-08 Medicare Program Integrity

Transmittal 123

Department of Health & Human Services (DHHS)

Center for Medicare & Medicaid Services (CMS)

Date: SEPTEMBER 23, 2005

CHANGE REQUEST 3703

SUBJECT: Chapter 3, MMA Section 935

I. SUMMARY OF CHANGES: This change implements portions of Section 935 of the MMA (entitled Recovery of Overpayments). Specifically, this CR explains to contractors their right to request documentation for a limited sample of submitted claims, after overpayments have been identified, in order to ensure the practice leading to the overpayments has ceased. This CR also specifies more clearly the number and method for selecting a probe sample.

NEW/REVISED MATERIAL

EFFECTIVE DATE: February 1, 2005

IMPLEMENTATION DATE: October 24, 2005

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:

R = REVISED, N = NEW, D = DELETED

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	3/3.2/Verifying Potential Errors and Setting Priorities
R	3/3.2.1/Determining Whether the Problem is Widespread or Provider Specific
R	3/3.8/Overpayment Procedures
R	3/3.11.1.2/"Probe" Reviews

III. FUNDING:

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2005 operating budgets.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Unless otherwise specified, the effective date is the date of service.

Attachment - Business Requirements

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SUBJECT: Chapter 3, MMA Section 935

I. GENERAL INFORMATION

A. Background: The MMA Section 935(a)(4) allows contractors to request documentation for a limited sample of submitted claims, after overpayments have been identified, in order to ensure the practice leading to the overpayments has ceased. The MMA Section 935(a)(8) requires CMS to establish a standard methodology for contractors to use when selecting sample claims for review in the case of an abnormal billing pattern.

B. Policy: The MMA Section 935(a)(4) and (8)

C. Provider Education: None.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3703.1	Contractors have the option to request the periodic production of records or supporting documentation for a limited sample of submitted claims from providers or suppliers to which amounts were previously overpaid to ensure that the practice leading to the overpayment is not continuing.	X	X	X	X					
3703.2	For post-pay review of an individual provider in the case of a possible provider specific problem, contractors should include in the probe sample a random or stratified sample of generally 20 -40 claims from that provider with dates of service from the period under review.	X	X	X	X					

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3703.3	For post-pay review in the case of a possible systemic problem, the contractor should generally include a random or stratified sample of 100 claims with dates of service from the period under review from across all providers or suppliers that bill the particular item or service in question.	X	X	X	X					
3703.4	For pre-pay review of an individual provider in the case of a possible provider specific problem, contractors should generally use the first 20 -40 claims submitted by the individual provider.	X	X	X	X					
3703.5	For pre-pay review in the case of a possible systemic problem, the contractor should include a random or stratified sample of generally 100 claims submitted from across all providers or suppliers that bill the particular item or service in question.	X	X	X	X					

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: February 1, 2005 **Implementation Date: October 24, 2005** **Pre-Implementation Contact(s):** **Misty Whitaker** **(410)786-3087** **Post-Implementation Contact(s):** **Misty Whitaker** **(410)786-3087**	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 20xx operating budgets.**

***Unless otherwise specified, the effective date is the date of service.**

3.2 – Verifying Potential Error and Setting Priorities

(Rev.123, Issued: 09-23-05, Effective: 02-01-05, Implementation: 10-24-05)

Understanding the characteristics of the service area of the provider is a key element of claim data analysis. The areas selected for review by the contractor (e.g., providers, services) must be deemed high priority and contractors must be able to document the rationale for selection. Using claims data, contractors shall determine the degree to which a potential error is widespread and decide if the potential error meets the deviation indicators established. When services and/or providers appear outside of norms, the contractor must verify that the potential error represents an unacceptable practice. Further investigate the provider(s) identified as causing the potential error.

Some examples of possible legitimate explanations for potential error are listed below. This is not an all-inclusive list.

- The provider may be associated with a medical school, research center, or may be a highly specialized facility; and
- The community may have special characteristics such as economic level or a concentration of a specific age group that leads to the aberrancy;

A. Error Validation Review

If no legitimate explanation exists for the potential error, the contractor should verify the cause of a potential error. The contractor shall not suspend large volumes of claims for review or use 100% prepayment review. Instead, the contractor shall select a sample of cases which is representative of the universe where the problem is occurring. The contractor shall request appropriate medical documentation and review cases for coverage and correct coding. MR staff should not be reviewing claims for compliance with other Medicare rules (i.e., claims processing, conditions of participation, etc.). Error validation reviews may be conducted on a prepayment or postpayment basis.

Where errors are verified, the contractor shall initiate appropriate corrective actions found in PIM, chapter 3, §§5, 6, 8, and 9.

Where no corrective action is taken, the contractor must document findings and explanations for not pursuing the problem. If no problems are found, the contractor shall discontinue the review. Do not wait until the end of the quarterly reporting period to end the review process.

In all situations where errors have been verified, the MR unit must notify the provider (written or verbal) that the particular practice or behavior is inappropriate and should not continue.

Error validation reviews require the examination of the provider's medical documentation but do not require use of statistical sampling for overpayment estimation methodologies. It does not allow projection of overpayments to the universe of claims reviewed. In this type of review, contractors collect overpayments only on claims that are actually reviewed, determined to be non-covered or incorrectly coded, and the provider is liable or at fault for the overpayment.

It may be used to determine:

- The extent of a problem across multiple providers, or
- Whether an individual provider has a problem.

Contractors shall select providers for Error Validation Reviews in, at a minimum, the following instances:

- The contractor has identified questionable billing practices, (i.e., noncovered or incorrectly coded services) through data analysis.
- Alerts from other intermediaries, carriers, QIOs, intermediary payment staff, or other internal components are received that warrant such review;
- Complaints.

Contractors must document their reasons for selecting the provider for the Error validation review. In all cases, they must clearly document the issues cited and the applicable law or their published national coverage policies or local medical review policy.

3.2.1 – Determining Whether the Problem is Widespread or Provider Specific

(Rev.123, Issued: 09-23-05, Effective: 02-01-05, Implementation: 10-24-05)

For each verified priority problem, the contractor must determine whether the problem is widespread or provider specific. If the error is a widespread problem and evenly distributed among providers, contractors should validate the concern by *following the instructions detailed in section 3.11.1.2 of this section.* Take service-specific corrective actions:

- Contact medical and specialty societies to assist in education; and
- Develop new/revised LMRPs/*LCDs* if needed; and/or
- Issue bulletin article clarifying rules; and/or
- Initiate service-specific prepay edits.

If the error is limited to a small number of providers, contractors should validate the concern by *following the instructions detailed in section 3.11.1.2 of this section*.

3.8 – Overpayment Procedures

(Rev.123, Issued: 09-23-05, Effective: 02-01-05, Implementation: 10-24-05)

The PSCs shall refer all identified overpayments to the AC who shall send the demand letter and recoup the overpayment.

Contractors should initiate recovery of overpayments whenever it is determined that Medicare has erroneously paid. In any case involving an overpayment, even where there is a strong likelihood of fraud, request recovery of the overpayment. PSCs and Medicare contractor BI units notify law enforcement of their intention to collect outstanding overpayments in cases in which they are aware of a pending investigation. There may be situations where OIG/OI or other law enforcement agencies might recommend that overpayments are postponed or not collected; however, this must be made on a case-by-case basis, and only when recovery of the overpayment would undermine the specific law enforcement actions planned or currently taking place. Medicare contractor BI units refer such requests to the RO (for PSCs, such requests are referred to the GTL, Co-GTL, and SME). If delaying recoupment minimizes eventual recovery, delay may not be appropriate. Medicare contractor BI units must forward any correspondence received from law enforcement requesting the overpayment not be recovered to the RO (PSCs forward this to the GTL, Co-GTL, and SME). The RO (for PSCs, the GTL, Co-GTL, and SME) will decide whether or not to recover.

If a large number of claims are involved, contractors consider using statistical sampling for overpayment estimation to calculate the amount of the overpayment. (See PIM, chapter 3, §3.10.)

Contractors have the option to request the periodic production of records or supporting documentation for a limited sample of submitted claims from providers or suppliers to which amounts were previously overpaid to ensure that the practice leading to the overpayment is not continuing. The contractor may take any appropriate remedial action described in this chapter if a provider or supplier continues to have a high level of payment error.

3.11.1.2 - "Probe" Reviews

(Rev.123, Issued: 09-23-05, Effective: 02-01-05, Implementation: 10-24-05)

Before deploying significant medical review resources to examine claims identified as potential problems from data analysis, take the interim step of selecting a small "probe" sample of potential problem claims (prepayment or postpayment) to validate the hypothesis that such claims are being billed in error. This ensures that medical review activities are targeted at identified problem areas. Such a sample should be large enough to provide confidence in the result, but small enough to limit administrative burden

For post-pay review of an individual provider in the case of a possible provider specific problem, contractors should include in the probe sample a random or stratified sample of generally 20 -40 claims from that provider with dates of service from the period under review. For post-pay review in the case of a possible systemic problem, the contractor should generally include a random or stratified sample of 100 claims with dates of service from the period under review from across all providers or suppliers that bill the particular item or service in question.

For pre-pay review of an individual provider in the case of a possible provider specific problem, contractors should generally use the first 20 -40 claims submitted by the individual provider. For pre-pay review in the case of a possible systemic problem, the contractor should include a random or stratified sample of generally 100 claims submitted from across all providers or suppliers that bill the particular item or service in question.

We recognize that in the pre-payment setting, obtaining a certain number of claims may be impossible if the provider stops billing Medicare.

For provider specific problems, notify providers (in writing or by telephone) that a probe sample is being done and of the result of the probe review. Contractors may use a letter similar to the letters in Program Integrity Manual (PIM) Exhibit 7 when notifying providers of the probe review and requesting medical records. Contractors may advise providers of the probe sample at the same time that medical records are requested.

Generally, a provider should be subject to no more than one probe review at any time; however, multiple probes may be conducted for very large billers as long as they will not constitute undue administrative burden.

For service specific probes (widespread probes) contractors must attempt to narrow the focus of the review so as to not place undue burden on providers. Contractors must strive to target only aberrant providers, to the extent possible, during the course of widespread probe reviews.