CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-08 Medicare Program Integrity	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 396	**Date: November 2, 2011**
	Change Request 7330

SUBJECT: Medical Review of PWK (paperwork)

I. SUMMARY OF CHANGES: Contractors are only required to review unsolicited documentation when the claim suspends for a medical review edit/audit. Contractors shall wait 7-10 calendar days for claims before reviewing claims with a PWK modifier.

EFFECTIVE DATE: April 1, 2012
IMPLEMENTATION DATE: April 2, 2012

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	3.2.2/Provider Notice
R	3.2.3/ Requesting Additional Documentation During Prepayment and Postpayment Review
R	3.2.3.8/ No or Insufficient Response to Additional Documentation Requests

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

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

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

Attachment - Business Requirements

Pub. 100-08	Transmittal: 396	Date: November 2, 2011	Change Request: 7330

SUBJECT: Medical Review of PWK (paperwork)

Effective Date: April 1, 2012

Implementation Date: April 2, 2012

I. GENERAL INFORMATION

A. Background: The Administrative Simplification provisions of HIPAA require the Secretary of HHS to adopt standard electronic transactions and code sets for administrative health care transactions. The Secretary may also modify these standards periodically.

CR 7306 and CR 7041 Implementation of the PWK (paperwork) segment of X12N Version 5010 establishes systems changes that are required to implement the PWK process at the contractors. This instruction is for Medical Review purposes only. It does not supercede instructions in CR 7306 and CR 7041 or elsewhere.

With the implementation of PWK, providers will be able to continue to submit electronic claims, even in those situations when the provider chooses to submit paper documentation at the time of claim submission. The development of a dedicated PWK process at the contractor, involving OCR/imaging technology, allows providers to continue utilizing cost effective electronic data interchange technology as well as provides cost savings for the Medicare program. Medicare contractors will be responsible for imaging, storage, and retrieval of the additional documentation for their claims examiners.

This instruction provides guidance on implementing medical review processes, procedures, and requirements for reviewing claims with a PWK segment and additional unsolicited documentation.

B. Policy: Contractor Medical Review (MR) departments are not required to review claims with a PWK indicator. Contractor MR departments shall continue to only subject to manual review those claims that the contractor believes are likely to contain improper payments. When a contractor chooses for manual review a claim that contains a PWK indicator, the contractor will wait a specified number of days to see if the paperwork arrives from the provider. At the end of the waiting period, if no paperwork has arrived, the contractor may send an additional documentation (ADR) request letter.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7330.1	Contractors, should, at their discretion, consider posting to their website or sending letters to providers informing them of the additional documentation that is needed to make a determination on a claim.	X	X	X	X	X					
7330.2	Contractors should inform providers that submission of the PWK segment and associated paperwork with their claims is voluntary.	X	X	X	X	X					
7330.3	Contractors are only required to review unsolicited documentation when the claim suspends for a medical review edit/audit.	X	X	X	X	X					
7330.4	Contractors shall not send an additional documentation request (ADR) for a claim with a PWK segment until after review of the unsolicited documentation.	X	X	X	X	X	X				
7330.5	Contractors shall allow seven calendar "waiting" days from the date of receipt of the claim for the PWK unsolicited documentation to be faxed.	X	X	X	X	X	X				
7330.6	Contractors shall allow ten calendar "waiting" days from the date of receipt of the claim for the PWK unsolicited documentation to be mailed.	X	X	X	X	X	X				
7330.7	Contractors serving island territories shall have the flexibility to adjust 'waiting days" as is necessary. CMS expects that any adjustment from the core seven/ten will be discussed with and approved by your contracting officer prior to implementation.	X	X	X	X	X	X				
7330.8	Contractors shall make a determination on the claim within 60 days after receipt of the PWK unsolicited documentation submitted within the "waiting days".	X	X	X	X	X	X	X			
7330.9	Contractors shall request additional documentation when they cannot make a determination on the claim after reviewing the unsolicited documentation.	X	X	X	X	X	X	X			
7330.10	Contractors shall then follow the "normal business procedures" for ADR as outlined in the Program Integrity Manual.	X	X	X	X	X	X				
7330.11	The normal business procedures for ADR shall include sending an ADR request to the provider, allowing 45 days for receipt of documentation, making a determination within 60 days of receipt of the last piece of documentation.	X	X	X	X	X	X				
7330.12	Contractors shall count as complex medical review	X	X	X	X	X	X	X			

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	claims for which the PWK unsolicited documentation was reviewed by the MR department whether or not an additional documentation request was issued.										

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	None.										

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below: N/A

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

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

Post-Implementation Contact(s): Contact your Contracting Officer's Technical Representative (COTR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers,* use only one of the following statements:

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

Section B: *For Medicare Administrative Contractors (MACs),* include the following statement:

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.

3.2.2 - Provider Notice

(Rev.396, Issued: 11-02-11, Effective: 04-01-12, Implementation: 04-02-12)

This section applies to MAC and Recovery Auditors, as indicated.

Because the CERT contractors select claims on a random basis, they are not required to notify providers of their intention to begin a review. The ZPICs are also not required to notify providers before beginning a review.

Providers may submit unsolicited documentation to the MAC when submitting a claim. Providers are to list the PWK 02 Report Transmission Code (PWK (paperwork) modifier) on the claim when submitting this documentation. MACs should inform the providers that they are NOT required to submit unsolicited documentation (and the corresponding PWK modifier) and that the absence or presence of PWK modifier does not mean that their claim will be reviewed. MACs should, at their discretion, consider posting to their website or sending letters to providers informing them of what additional documentation is needed to make a determination on the claim.

A. Notice of Provider-Specific Review

When MAC data analysis indicates that a provider-specific potential error exists that cannot be confirmed without requesting and reviewing documentation associated with the claim, the MAC shall review a sample of representative claims. Before deploying significant medical review resources to examine claims identified as potential problems through data analysis, MACs shall take the interim step of selecting a small "probe" sample of generally 20-40 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. The MACs shall ensure that such a sample is large enough to provide confidence in the result, but small enough to limit administrative burden. The CMS encourages the MACs to conduct error validation reviews on a prepayment basis in order to help prevent improper payments. MACs shall select providers for error validation reviews in the following instances, at a minimum:

- The MAC has identified questionable billing practices (e.g., non-covered, incorrectly coded or incorrectly billed services) through data analysis;
- The MAC receives alerts from other MACs, Quality Improvement Organizations (QIOs), CERT, Recovery Auditors, OIG/GAO, or internal/external components that warrant review;
- The MAC receives complaints; or,
- The MAC validates the items bulleted in§ 3.2.1.

Provider-specific error validation reviews are undertaken when one or a relatively small number of providers seem to be experiencing the same problem with billing. The MACs shall document their reasons for selecting the provider for the error validation review. In all cases, they shall clearly document the issues noted and cite the applicable law, published national coverage determination, or local coverage determination.

For provider-specific problems, the MAC shall notify providers in writing that a probe sample review is being conducted. *MACs should, at their discretion, consider sending letters to providers informing them of what additional documentation is needed to make a determination on the claim.* MACs have the discretion to use a letter similar to the letters in Exhibit 7 of the PIM when notifying providers of the probe review and requesting documentation. MACs have the discretion to advise providers of the probe sample at the same time that medical documentation or other documentation is requested.

Generally, MACs shall subject a provider to no more than one probe review at any time; however, MACs have the discretion to conduct multiple probes for very large billers as long as they will not constitute undue administrative burden.

MACs

The MACs shall notify selected providers prior to beginning a provider-specific review by sending an individual written notice. MACs shall indicate whether the review will occur on a prepayment or postpayment basis. This notification may be issued via certified letter with return receipt requested. MACs shall notify providers of the specific reason for selection. If the basis for selection is comparative data, MACs shall provide the data on how the provider varies significantly from other providers in the same specialty, jurisdiction, or locality. Graphic presentations help to communicate the perceived problem more clearly.

Recovery Auditors

The Recovery Auditors are required to post a description of all approved new issues to the Recovery Auditor's Web site before correspondence is sent to the provider. After posting, the Recovery Auditor should issue an additional documentation request (ADR) to the provider, if warranted.

B. Notice of Service-Specific Review

This section applies to MACs and Recovery Auditors, as indicated.

Service-specific reviews are undertaken when the same or similar problematic process is noted to be widespread and affecting one type of service (e.g., providing tube feedings to home health beneficiaries across three (3) States).

MACs

The MACs shall provide notification prior to beginning a service-specific review by either posting a review description on its Web site, or by sending individual written notices, such as an ADR, to the affected providers. MACs have the discretion to issue the notice separately or include it in the ADR. *MACs should, at their discretion, consider posting to their website or sending letters to providers informing them of what additional documentation is needed to make a determination on the claim*

When MAC data analysis confirms that an improper payment can be prevented through service-specific complex review, the MAC shall install service-specific complex review edits as soon as feasible under their MR Strategy. The MAC is not required to conduct an error validation review prior to installing these edits.

Recovery Auditors

Before beginning widespread service-specific reviews, Recovery Auditors shall notify the provider community that the Recovery Auditor intends to initiate review of certain items/services through a posting on the Recovery Auditor Web site describing the item/service that will be reviewed. Additionally, for complex reviews, the Recovery Auditors shall send ADRs to providers that clearly articulate the items or services under review and indicate the appropriate documentation to be submitted.

3.2.3 - Requesting Additional Documentation During Prepayment and Postpayment Review

(Rev. 396, Issued: 11-02-11, Effective: 04-01-12, Implementation: 04-02-12)

This section applies to MACs, CERT, Recovery Auditors, and ZPICs, as indicated.

A. General

In certain circumstances, the MACs, CERT, Recovery Auditors, and ZPICs 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). MACs, CERT, Recovery Auditors, and ZPICs 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, Recovery Auditor, and ZPIC 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

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."

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 seven calendar "waiting" days (from the date of receipt) for additional the unsolicited documentation to be faxed or ten 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 seven/ten will be discussed with and approved by your contracting officer prior to implementation. When the documentation is received, the contractor has 60 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 PIM. These procedures include: sending an ADR request to

the provider, allowing 45 days for receipt of documentation, making a determination within 60 days of receipt the last piece of documentation.

3.2.3.8 - No or Insufficient Response to Additional Documentation Requests

(Rev. 396, Issued: 11-02-11, Effective: 04-01-12, Implementation: 04-02-12)

This section applies to MACs, Recovery Auditors, and ZPICs, as indicated.

A. Additional Documentation Requests

If information is requested from both the billing provider or supplier and a third party and no response is received from either within 45 calendar days for MACs and Recovery Auditors or 30 calendar days for ZPICs after the date of the request (or within a reasonable time following an extension), the MACs, Recovery Auditors and ZPICs shall deny the claim, in full or in part, as not reasonable and necessary. These claims denials are issued with Remittance Advice Code N102/56900 that reads "This claim has been denied without reviewing the medical record because the requested records were not received or were not received timely." Contractors shall count these denials as automated review or manual review depending on the method of development. *For claims that had a PWK modifier, and the unsolicited documentation was reviewed, the review shall be counted as complex review.*

B. No Response

During prepayment review, if no response is received within 45 calendar days after the date of the ADR, the MACs, and ZPICs shall deny the claim.

During postpayment review, if no response is received within 45 calendar days after the date of the ADR (or extension), the MACs and Recovery Auditors shall deny the claim as not reasonable and necessary and count these denials as non-complex reviews. ZPICs shall deny the claim as not meeting reasonable and necessary criteria if no response is received within 30 calendar days. Recovery Auditors shall report these denials as "No Response Denials." Recovery Auditors shall not count these as complex or non-complex reviews. Ambulance claims may be denied based on §1861(s) (7) of the Act.

C. Insufficient Response

If the MAC, CERT, Recovery Auditor, or ZPIC requests additional documentation to verify compliance with a benefit category requirement, and the submitted documentation lacks evidence that the benefit category requirements were met, the reviewer shall issue a benefit category denial. If the submitted documentation includes defective information (the documentation does not support the physician's certification), the reviewer shall deny the claim as not meeting the reasonable and necessary criteria.