

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 441	Date: November 23, 2012
	Change Request 8093

SUBJECT: Retirement of the Program Integrity management Reporting (PIMR) System

I. SUMMARY OF CHANGES: The purpose of this change request is to notify all Medicare contractors and shared system maintainers that the Centers for Medicare and Medicaid Services (CMS) will discontinue the direct reporting and collecting of medical review data to the PIMR. The system is being retired.

EFFECTIVE DATE: April 1, 2013 (FISS and MCS); July 1, 2013 (VMS)

IMPLEMENTATION DATE: April 1, 2013 (Implementation of FISS and MCS); July 1, 2013 (Implementation of VMS)

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/Medical Review Definitions
R	7/7.2.1/Background
R	7/7.2.2/ Definitions
N	7/7.2.2.1/ Automated Medical Review
N	7/7.2.2.2/ Routine Medical Review
N	7/7.2.2.3/Demand Bill Claims Review
N	7/7.2.2.4/Medical Review Reopening
N	7/7.2.2.5/ Prepay Complex Provider Specific Review
N	7/7.2.2.6/ Prepay Complex Service Specific Review
N	7/7.2.2.7/ Prepay Complex Provider Specific Probe Review
N	7/7.2.2.8/ Prepay Complex Service Specific Probe Review
N	7/7.2.2.9/ Advanced Determination of Medicare Coverage (ADMC)
N	7/7.2.2.10/ Postpay Complex Provider Specific Probe Review
N	7/7.2.2.11/ Postpay Complex Service Specific Probe Review
N	7/7.2.2.12/ Postpay Complex Provider Specific Review
N	7/7.2.2.13/ Postpay Complex Service Specific Review
N	7/7.2.2.14/Data Analysis
N	7/7.2.2.15/Policy Development
N	7/7.2.2.16/Medical Review Edit Development
N	7/7.2.2.17/Externally Directed Reviews
N	7/7.2.2.18/Provider Compliance Group Directed Reviews
R	7/7.2.3/Coding Decisions
R	7/7.2.4/Monthly Reporting of Medical Review Savings
R	7/7.2.5/Reserved
R	7/7.2.6/Reserved
R	7/7.2.7/Reserved

III. FUNDING:

For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; contractor's activities are to be carried out with 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 obliged 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: 441	Date: November 23, 2012	Change Request: 8093
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SUBJECT: Retirement of the Program Integrity management Reporting (PIMR) System

EFFECTIVE DATE: April 1, 2013 (FISS and MCS); July 1, 2013 (VMS)

IMPLEMENTATION DATE: April 1, 2013 (Implementation of FISS and MCS); July 1, 2013 (Implementation of VMS)

I. GENERAL INFORMATION

A. Background: The purpose of this change request is to notify all Medicare contractors and shared system maintainers that the Centers for Medicare & Medicaid Services (CMS) is retiring the PIMR system and discontinuing the direct reporting and collecting of medical review data to PIMR.

PIMR collects the cost, savings, and workload data relative to medical review activities. Data was reviewed to ensure compliance with CMS reporting requirements, improve performance, operations, and report accomplishments as a result of the medical review process.

B. Policy: N/A

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility										
		A/B MAC		D M E	F I E	C A R	R I E R	Shared- System Maintainers				Other
		P a r t A	P a r t B					F I S S	M C S	V M S	C W F	
8093.1	All Medicare Administrative Contractors (MACs) shall discontinue entering data into the PIMR system by July 1, 2012.	X	X	X				X	X			
8093.2	CMS data centers shall discontinue the transmission of summarized to PIMR as of July 1, 2012.	X	X	X				X	X			
8093.3	Shared system Maintainers shall update their software to remove processes that allow data to be loaded to the PIMR. April 1, 2013 (Implementation for FISS and MCS) July 1, 2013 (Implementation for VMS)							X	X	X		
8093.4	The Medicare Administrative Contractors, FIs and Carriers shall submit the Medical Review Savings report by the 20th of every month as a deliverable in CMS ARTs.	X	X	X	X	X	X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility						
		A/B MAC	D M E	F I	C A R R I E R	R H H I	Other	
		P a r t A	P a r t B	M A C				
	None							

IV. SUPPORTING INFORMATION

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

X-Ref Requirement Number	Recommendations or other supporting information:
	The PIMR system no longer meets the business and technologic requirements of the Office of Financial Management, Provider Compliance Group.

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

V. CONTACTS

Pre-Implementation Contact(s): Vicki Chitwood, 410-786-7776 or Vicki.Chitwood@cms.hhs.gov , Raymond McMasters, 410-786-0753 or Raymond.Mcmasters@cms.hhs.gov (COR) , George Mills, 410-786-7450 or George.Mills@cms.hhs.gov (Director Provider Compliance Group-Business Owner)

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

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers:

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

Section B: For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS do 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.

Medicare Program Integrity Manual

Chapter 7 - MR Reports

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7.2 - Medical Review Activity Definitions

(Rev. 441, 11-23-12, Effective: 04- 01- 13 (FISS and MCS); 07-01-13 (VMS))

7.2.1 - Background

(Rev. 441, 11-23-12, Effective: 04- 01- 13 (FISS and MCS); 07-01-13 (VMS))

This section provides requirements and instructions for Part A, Part B, and Durable Medical Equipment (DME) MACs, fiscal intermediaries (FIs), and carriers.

The reporting requirements for Medical Review (MR) activities performed by the Contractor were formerly captured in the Program Integrity Management Reporting (PIMR) system. Effective 7/1/2012, the PIMR system was retired, requiring the revision to this chapter of the Program Integrity Manual.

The new process for the oversight of Medical Review activities administered by the Contractor will improve the management of medical review cost, savings, and workload. The manual Medical Review Savings reporting process will replace the Program Integrity Manual Review system.

The Medical Review, savings, and workload data shall be collected through the use of a manual report until such a time that it is decided that an automated reporting system is required and developed to meet the business needs of The CMS Office of Financial Management, Provider Compliance Group, Division of Medical Review and Education. The CMS will obtain Medical Review Savings data through manual reporting by Contractor staff. Those reports will be due monthly, on the 20th day of the month.

7.2.2 - Definitions

(Rev. 441, 11-23-12, Effective: 04- 01- 13 (FISS and MCS); 07-01-13 (VMS))

The reporting process will require data that can be classified under three different categories of activity measures: Workload, Cost, and Savings. The Medical Review definitions shall apply to all Medical Review activities and shall not be deviated from or interpreted differently than stated below. The consistency in the application of these definitions will provide validity to the data reported that is required to assess the effectiveness of the CMS Medical Review and Education Program being administered by the Contractor(s)

MEDICAL REVIEW

The review of claims and associated medical documentation that occurs when review staff:

- 1. Make a coverage decision (benefit category, statutory exclusion, or reasonable and necessary) and a coding decision to determine the appropriate payment for claims, or*
- 2. Investigate complaints to determine whether a corrective action was effective (e.g., an MR activity such as provider notification letter), or identify situations that require prepayment edits or the development of a local coverage determination (LCD).*

The MR process requires the application of clinical judgment either as part of a review, in writing policies, or in the development of guidelines and processing instructions. For local MR edits, input must be from the Contractor Medical Review clinicians/staff. For national edits, input from the Contractor medical/clinical staff is not necessary. The MR can be performed either before or after the claim has been paid. Generally, a line cannot result in MR workload or savings if it is not referred to MR. A line that potentially involves both MR and claims processing work should suspend to a claims processing reviewer, and that reviewer should refer the line to MR only if the claims processing reviewer cannot make a decision based on guidelines available to that reviewer.

Do NOT consider the review as MR if it requires:

- 1. Pricing Only, or**
- 2. Coding Only, or**

3. Pricing and Coding only.

Consider the review as MR if:

1. Pricing is based on medical review determination. or
2. Coding is based on medical review determination, or
3. Coding and Pricing are based on medical review determination.

If an automated claims processing edit has already made a decision to pay, and the claim only suspends for pricing, consider the review automated claims processing and do not count it for MR workload or costs.

7.2.2.1 Automated Medical Review

(Rev. 441, 11-23-12, Effective: 04- 01- 13 (FISS and MCS); 07-01-13 (VMS))

A medical review is considered automated when a payment decision is made at the system level, using available electronic information, with no human intervention. It must be based on guidelines for which the contractor's Medical Review area has developed some or all of the logic for review of specific billing and coverage criteria based on vulnerabilities identified by the Contractor's Medical Review area. This process is done completely through the Medical Review Contractors' technology developed in response to medical review data analysis.

7.2.2.2 Routine Medical Review

(Rev. 441, 11-23-12, Effective: 04- 01- 13 (FISS and MCS); 07-01-13 (VMS))

Routine Review uses human intervention, but only to the extent that the reviewer reviews a claim or any attachment submitted by the provider. It does not require clinical judgment in review of medical records. Routine medical reviews target all claims that meet an established pre-existing set of billing and coverage criteria created to assess a vulnerability identified in the medical review area. If the requested documentation is not received, the review can still be considered routine. This is a "document only" review that is performed by specially trained non-clinical Medical Review staff. For example, non-clinical MR staff reviews a document for stop and start dates, dose ranges, attachment of CMN as required, etc.

7.2.2.3 Demand Bill Claims Review

(Rev. 441, 11-23-12, Effective: 04- 01- 13 (FISS and MCS); 07-01-13 (VMS))

Demand bills are submitted at the beneficiary's/representative's request because the beneficiary disputes the provider's opinion that the bill will not be paid by Medicare and requests the bill be submitted for a payment determination. The demand bill is identified by the presence of a condition code 20. There must be a written request from the beneficiary to submit the bill, unless the beneficiary is deceased or incapable of signing. In this case, the beneficiary's guardian, relative or other authorized representative may make the request. This includes SNF and HHA demand bills as well as other demand bills (outpatient) and Third Party Liability Medical Reviews.

7.2.2.4 Medical Review Reopening

(Rev. 441, 11-23-12, Effective: 04- 01- 13 (FISS and MCS); 07-01-13 (VMS))

A MR reopening is a remedial action taken to review and change a final determination or decision that resulted in either an overpayment or an underpayment, even though the determination for decision was correct based on the evidence in the record. It is separate and distinct from the appeals process. The Contractor may choose to reopen a claim for late documentation. The MR department shall conduct a reopening of claims sent by the appeals department which meet the criteria in IOM Pub. 100-4, Section 10.3. (1) A provider failed to timely submit documentation through an Additional Documentation Request (ADR) (2) Claim was denied because the requested documentation was not received timely (3) the requested documentation is received after the 45 day period with or without a request for redetermination or

reopening AND (4) The request is filed within 120 days of the receipt of the initial determination. Do not count more than one reopening per claim.

7.2.2.5 Prepay Complex Provider Specific Review

(Rev. 441, 11-23-12, Effective: 04- 01- 13 (FISS and MCS); 07-01-13 (VMS))

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 569001/N102 denial. For the purpose of calculating and reporting MR workload, cost and savings, this is prepay complex review and is not to be counted as a probe review.

7.2.2.6 Prepay Complex Service Specific review

(Rev. 441, 11-23-12, Effective: 04- 01- 13 (FISS and MCS); 07-01-13 (VMS))

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 569001/N102 denial. For the purpose of calculating and reporting MR workload, cost and savings, this is prepay complex review and is not to be counted as a probe review.

7.2.2.7 Prepay Complex Provider Specific Probe Review

(Rev. 441, 11-23-12, Effective: 04- 01- 13 (FISS and MCS); 07-01-13 (VMS))

Complex medical review requires a licensed medical professional to use clinical review judgment to evaluate medical records. Prepay complex probe reviews are done to verify that the program vulnerability identified through data analysis actually exists and will require education and possible targeted medical review. In the case of a possible provider specific problem, contractors should generally use a sample of 20 -40 claims submitted by that individual provider.

The Contractor shall validate data analysis findings by conducting probe reviews and implementing the necessary PCAs in accordance with IOM Pub.100-08 Chapter 3. Once a problem has been verified, the Contractor shall implement the necessary PCA. This includes providing the initial notification informing the provider of the results of the probe review, and collaborating with Provider Outreach and Education (POE) to share potential educational needs, and making referrals to POE, ZPICs, RACs, or others as appropriate.

7.2.2.8 Prepay Complex Service Specific Probe Review

(Rev. 441, 11-23-12, Effective: 04- 01- 13 (FISS and MCS); 07-01-13 (VMS))

Complex medical review requires a licensed medical professional to use clinical review judgment to evaluate medical records. Prepay complex service specific probe reviews are done to verify that the program vulnerability identified through data analysis actually exists and will require education and possible targeted medical review. For Prepay review in the case of a possible systemic problem, the contractor shall 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.

The Contractor shall validate data analysis findings by conducting probe reviews and implementing the necessary PCAs in accordance with IOM Pub.100-08 Chapter 3. Once a problem has been verified, the Contractor shall implement the necessary PCA. This includes providing the initial notification of the results of the probe review, and collaborating with Provider Outreach and Education (POE) to share potential educational needs, and making referrals to POE, ZPICs, RACs or others as appropriate.

7.2.2.9 Advance Determination Medicare Coverage (ADMC)
(Rev. 441, 11-23-12, Effective: 04- 01- 13 (FISS and MCS); 07-01-13 (VMS))

At the request of a supplier or beneficiary, the DME MAC may determine in advance of delivery of an item whether payment for that item is medically necessary. The request must contain adequate information from the patient's medical record to identify the patient for whom the item is intended, the intended use of the item, and the medical condition of the patient that necessitates the use of the item.

7.2.2.10 Postpay Complex Provider Specific Probe Review
(Rev. 441, 11-23-12, Effective: 04- 01- 13 (FISS and MCS); 07-01-13 (VMS))

Complex medical review requires a licensed medical professional to use clinical review judgment to evaluate medical records. Postpay complex provider specific probe reviews are done to verify that the program vulnerabilities identified through data analysis actually exist and will require education and/or further medical review. For postpay review of an individual provider in the case of a possible provider specific problem, contractors shall 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.

The Contractor shall validate data analysis findings by conducting probe reviews and implementing the necessary PCAs in accordance with, IOM Pub. 100-08 Chapter 3. Once a problem has been verified, the Contractor shall implement the necessary PCA. This includes providing the initial notification informing the provider of the results of the probe review, and collaborating with Provider Outreach and Education (POE) to share potential educational needs, and making referrals to POE, ZPICs, RACs or others as appropriate.

7.2.2.11 Postpay Complex Service Specific Probe Review
(Rev. 441, 11-23-12, Effective: 04- 01- 13 (FISS and MCS); 07-01-13 (VMS))

Complex medical review requires a licensed medical professional to use clinical review judgment to evaluate medical records. Postpay complex service specific probe reviews are done to verify that the program vulnerabilities identified through data analysis actually exist and will require education and/or further medical review. For Postpay review in the case of a possible service/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.

The Contractor shall validate data analysis findings by conducting probe reviews and implementing the necessary PCAs in accordance with, IOM Pub. 100-08 Chapter 3. Once a problem has been verified, the Contractor shall implement the necessary PCA. This includes providing the initial notification of the results of the probe review, and collaborating with Provider Outreach and Education (POE) to share potential educational needs, and making referrals to POE, ZPICs, RACs or others as appropriate.

7.2.2.12 Postpay Complex Provider Specific Review
(Rev. 441, 11-23-12, Effective: 04- 01- 13 (FISS and MCS); 07-01-13 (VMS))

Complex medical review requires a licensed medical professional to use clinical review judgment to evaluate medical records. Provider specific postpay medical review of claims requires that a benefit category review, statutory exclusion review, and/or reasonable and necessary review be made after claim payment directed at an individual provider. 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. The failure of the provider to submit documentation shall result in a 569001/N102 denial. For the purpose of calculating and reporting MR workload, cost and savings, this is postpay complex review and is not to be counted as a probe review.

7.2.2.13 Postpay Complex Service Specific Review

(Rev. 441, 11-23-12, Effective: 04- 01- 13 (FISS and MCS); 07-01-13 (VMS))

Complex medical review requires a licensed medical professional to use clinical review judgment to evaluate medical records. Service specific postpay medical review of claims requires that a benefit category review, statutory exclusion review, and/or reasonable and necessary review be made after claim payment directed at a certain service. 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, it is not considered a complex review. The failure of the provider to submit documentation shall result in a 569001/N102 denial. For the purpose of calculating and reporting MR workload, cost and savings, this is postpay complex review and is not to be counted as a probe review.

7.2.2.14 Data Analysis

(Rev. 441, 11-23-12, Effective: 04- 01- 13 (FISS and MCS); 07-01-13 (VMS))

Used to identify and verify potential errors to produce the greatest protection for the Medicare program. Data analysis is an essential first step in determining whether patterns of claims submission and payment indicate potential problems. It includes simple identification of aberrancies in billing patterns within a homogeneous group, or much more sophisticated detection of patterns within claims or groups of claims that might suggest improper billing or payment. Data analysis is undertaken as a part of general surveillance and review of submitted claims, conducted in response to information about specific problems stemming from complaints, provider or beneficiary input, fraud alerts, reports from CMS, other ACs, MACs, or independent government and nongovernmental agencies.

Background

The Contractor uses CERT findings, internal and external data sources, review of claims, and information from other operational areas to identify patterns of erroneous billing submissions and areas of over utilization to target provider-specific review.

7.2.2.15 Policy Development

(Rev. 441, 11-23-12, Effective: 04- 01- 13 (FISS and MCS); 07-01-13 (VMS))

Contractor policy development involves determining that a Local Coverage Determination (LCD) is needed, using or adapting an existing LCD or model policy, or developing an LCD using medical consultants, input from professional organizations, and information from medical literature to address aberrant utilization under benefit category for an item/service.

7.2.2.16 Medical Review Edit Development

(Rev. 441, 11-23-12, Effective: 04- 01- 13 (FISS and MCS); 07-01-13 (VMS))

Medical Review edit development includes all activities necessary to create and set up a computerized logic test developed with the assistance of health professionals that compares the data elements on a Medicare claim for the purposes of: (1) making a local coverage or coding determination; or (2) suspending a claim so such determinations can be made by appropriate Medical Review personnel prior to or after payment of the claim.

7.2.2.17 Externally Directed Reviews

(Rev. 441, 11-23-12, Effective: 04- 01- 13 (FISS and MCS); 07-01-13 (VMS))

Medical reviews directed by or directly supporting the OIG, law enforcement, ZPICs, or court orders, when funded by CMS.

7.2.2.18 Provider Compliance Group Directed Reviews

(Rev. 441, 11-23-12, Effective: 04- 01- 13 (FISS and MCS); 07-01-13 (VMS)

Includes only those Medical reviews and special studies directed by or directly supporting action requested by the Provider Compliance Group (PCG). Contractors shall only count workload under this category as directed or requested by PCG and their COTR.

7.2.3 Coding Decisions

(Rev. 441, 11-23-12, Effective: 04- 01- 13 (FISS and MCS); 07-01-13 (VMS)

Where used in this Chapter, the term “coding decisions” generally refers to MR decisions. For example, coding decisions include each of the following:

- *Contractor reviews product information for a durable medical equipment prosthetics, orthotics, and supplies (DMEPOS) item, finds that the wrong code has been billed based upon the review of diagnoses codes and narrative information included on the claim/bill, changes the code to the correct code, and completes the claim.
In the situation described above, the Contractor denies the claim line with the wrong code and uses the message that the supplier has incorrectly coded the item.*
- *The Contractor determines that a service billed as a bilateral x-ray is a single view x-ray and indicates a down code to a single view x-ray in the remittance advice.*

Include only coding decisions that require the application of clinical judgment as part of a review, in writing policies, or in the development of guidelines and processing instructions.

7.2.4 Monthly Reporting of Medical Review Savings

(Rev. 441, 11-23-12, Effective: 04- 01- 13 (FISS and MCS); 07-01-13 (VMS)

The Contractor shall utilize the definitions in C.5.12.4 to report those savings resulting from medical review. The report shall be submitted by the 20th day of each calendar month and submitted as a deliverable via the CMS ART portal. The activities and metrics to be reported for calculating Medical Review Savings are detailed in the spreadsheet below. The reporting template is an attachment distributed with TDL-12070. The template, developed by the Provider Compliance Group, includes the formulas required to calculate MR savings and shall not be altered or deviated from.

Medical Review Savings Report Template Sample next page:

Monthly Medical Review Reporting for Prepay & Postpay Review Activity - Contractor/MAC #

ACTIVITY	METRIC	SEPT 2011	OCT 2011	NOV 2011	DEC 2011	JAN 2012	FEB 2012	MAR 2012	APR 2012	MAY 2012	JUN 2012	JUL 2012	AUG 2012	SEPT 2012	TOTAL 2012
Automated MR	# Claims														0
Automated MR	# Claims Denied														0
Automated MR	\$'s Denied														\$0
Automated MR	\$'s Reversed														\$0
Automated MR	\$'s Saved	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Routine MR	# Claims														0
Routine MR	# Claims Denied														0
Routine MR	\$'s Denied														\$0
Routine MR	\$'s Reversed														\$0
Routine MR	\$'s Saved	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Demand Bill Claims MR	# Claims														0
Demand Bill Claims MR	# Claims Denied														0
Demand Bill Claims MR	\$'s Denied														\$0
Demand Bill Claims MR	\$'s Reversed														\$0
Demand Bill Claims MR	\$'s Saved	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Prepay Complex Provider	# Claims														0
Prepay Complex Provider	# Claims Denied														0
Prepay Complex Provider	\$'s Denied														\$0
Prepay Complex Provider	\$'s Reversed														\$0
Prepay Complex Provider	\$'s Saved	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Prepay Complex Service	# Claims														0
Prepay Complex Service	# Claims Denied														0
Prepay Complex Service	\$'s Denied														\$0
Prepay Complex Service	\$'s Reversed														\$0
Prepay Complex Service	\$'s Saved	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Prepay Complex Probe	# Claims														0
Prepay Complex Probe	# Claims Denied														0
Prepay Complex Probe	\$'s Denied														\$0
Prepay Complex Probe	\$'s Reversed														\$0
Prepay Complex Probe	\$'s Saved	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Postpay Complex Probe	# Claims														0
Postpay Complex Probe	# Claims Denied														0
Postpay Complex Probe	\$'s Denied														\$0
Postpay Complex Probe	\$'s Reversed														\$0
Postpay Complex Probe	\$'s Saved	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Postpay Complex Provider	# Claims														0
Postpay Complex Provider	# Claims Denied														0
Postpay Complex Provider	\$'s Denied														\$0
Postpay Complex Provider	\$'s Reversed														\$0
Postpay Complex Provider	\$'s Saved	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Postpay Complex Service	# Claims														0
Postpay Complex Service	# Claims Denied														0
Postpay Complex Service	\$'s Denied														\$0
Postpay Complex Service	\$'s Reversed														\$0
Postpay Complex Service	\$'s Saved	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
TOTAL	# Claims	0	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	# Claims Denied	0	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	\$'s Denied	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
TOTAL	\$'s Reversed	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
TOTAL	\$'s Saved	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0

7.2.5 - Reserved

(Rev. 441, 11-23-12, Effective: 04- 01- 13 (FISS and MCS); 07-01-13 (VMS))

7.2.6 - Reserved

(Rev. 441, 11-23-12, Effective: 04- 01- 13 (FISS and MCS); 07-01-13 (VMS))

7.2.7 - Reserved

((Rev. 441, 11-23-12, Effective: 04- 01- 13 (FISS and MCS); 07-01-13 (VMS))