CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-08 Medicare Program Integrity	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 613	**Date: September 25, 2015**
	Change Request 9323

SUBJECT: Postpayment Review Requirements

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to provide instructions to Medicare Administrative Contractors (MACs) on counting the 60 day time period for review of claims.

EFFECTIVE DATE: October 26, 2015
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 26, 2015

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	3/3.1.1 - Complex Medical 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: 613	Date: September 25, 2015	Change Request: 9323

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I. GENERAL INFORMATION

A. Background: When reviewing claims on a post-payment basis, the MACs may refer claims to a Zone Program Integrity Contractor (ZPIC) for investigation. The MACs shall stop counting the 60-day time frame for review when a referral is made to a ZPIC. When the appeals department receives documentation for claims that were denied due to no documentation being received by the Medical Review (MR) department, appeals sends these claims back to MR for review. These claims are referred to as re-openings. The MR department shall count the 60 day timeframe for review when the claim is received in the MR department.

B. Policy: There are no statutory or regulatory policies that impact this CR.

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	
9323.1	MACs shall stop counting the 60-day time period for review for claims when the claim is referred to the ZPIC.	X	X	X	X					
9323.2	MACs shall begin counting the 60-day time period for review of records for reopenings when they are received in the MR department from the Appeals department.	X	X	X	X					RRB-SMAC

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		

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): Debbie Skinner, 410-786-7480 or debbie.skinner@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

3.3.1.1 - Complex Medical Review

(Rev.613, Issued: 09-25-15, Effective: 10-26-15, Implementation: 10-26-15)

This section applies to MACs, CERT, Recovery Auditors, Supplemental Medical Review Contractor(s) and ZPICs, as indicated.

A. Credentials of Reviewers

The MACs, CERT, and ZPICs shall ensure that complex reviews for the purpose of making coverage determinations are performed by licensed nurses (RNs and LPNs) or physicians, unless this task is delegated to other licensed health care professionals. Recovery Auditors and the Supplemental Medical Review Contractor(s) shall ensure that the credentials of their reviewers are consistent with the requirements in their respective SOWs.

During a complex review, nurse and physician reviewers may call upon other health care professionals (e.g., dieticians or physician specialists) for advice. The MACs, CERT, and ZPICs shall ensure that services reviewed by other licensed health care professionals are within their scope of practice and that their MR strategy supports the need for their specialized expertise in the adjudication of particular claim type (i.e., speech therapy claim, physical therapy). Recovery Auditors and the Supplemental Medical Review Contractor(s) shall follow guidance related to calling upon other healthcare professionals as outlined in their respective SOWs.

Recovery Auditors shall ensure that complex reviews for the purpose of making coding determinations are performed by certified coders. CERT and MACs are encouraged to make coding determinations by using certified coders. ZPICs have the discretion to make coding determinations using certified coders.

B. Credential Files

The MACs, CERT, Recovery Auditors, and ZPICs shall maintain a credentials file for each reviewer (including consultants, contract staff, subcontractors, and temporary staff) who performs complex reviews. The credentials file shall contain at least a copy of the reviewer's active professional license.

C. Quality Improvement (QI) Process

The MACs, CERT, Recovery Auditors, and Supplemental Medical Review Contractor(s) shall establish a Quality Improvement (QI) process that verifies the accuracy of MR decisions made by licensed health care professionals. The MACs, CERT, Recovery Auditors, and Supplemental Medical Review Contractor(s) shall attend the annual medical review training conference as directed by the CMS and/or their SOW. The MACs, CERT, Recovery Auditors, and Supplemental Medical Review Contractor(s) shall include inter-rater reliability assessments in their QI process and shall report these results as directed by CMS.

D. Advanced Beneficiary Notice (ABN)

The MACs, CERT, Recovery Auditors, ZPICs, and Supplemental Medical Review Contractor(s) shall request as part of the ADR, during a complex medical record review, a copy of any mandatory ABNs, as defined in Pub. 100-04, Medicare Claims Processing Manual Chapter 30 section 50.3.1. If the claim is determined not to be reasonable and necessary, the contractor will perform a face validity assessment of the ABN in accordance with the instructions stated in Pub. 100-04 Medicare Claims Processing Manual chapter 30 section 50.6.3.

The Face Validity assessments do not include contacting beneficiaries or providers to ensure the accuracy or authenticity of the information. Face Validity assessments will assist in ensuring that liability is assigned in accordance with the Limitations of Liability Provisions of section 1879 of the Social Security Act.

E. MAC Funding Issues

The MAC complex medical review work performed by medical review staff for purposes other than MR (e.g., appeals) shall be charged, for expenditure reporting purposes, to the area requiring medical review services.

All complex review work performed by MACs shall:

- Involve activities defined under the Medicare Integrity Program (MIP) at Section 1893(b)(1) of the Act;
- Be articulated in its medical review strategy; and,
- Be designed in such a way as to reduce its Comprehensive Error Rate Testing (CERT) error rate or prevent the contractor's error rate from increasing.

The MACs shall be mindful that edits suspending a claim for manual review to check for issues other than inappropriate billing (i.e. completeness of claims, conditions of participation, quality of care) are not medical review edits as defined under Section 1893(b)(1) of the Act and cannot be funded by MIP. Therefore, edits resulting in work other than that defined in Section1893 (b) (1) shall be charged to the appropriate Program Management activity cost center.

F. Review Timeliness Requirements

Prepayment Review Requirements for MACs

When a MAC receives requested documentation for prepayment review within 45 calendar days of the date of the ADR, the MAC shall do the following within 30 calendar days of receiving the requested documentation: 1) make and document the review determination and 2) enter the decision into the Fiscal Intermediary Shared System (FISS), Multi-Carrier System (MCS), or the VIPS Medicare System (VMS). The 30 calendar day timeframe applies to prepayment routine reviews, prepayment complex reviews and prepayment documentation compliance reviews. The 30 calendar day timeframe does not apply to prepayment reviews of Third Party Liability claims. The MACs shall make and enter a review determination for Third Party Liability claims within 60 calendar days.

Postpayment Review Requirements for MACs

The MAC shall make a review determination, and mail the review results notification letter to the provider within 60 calendar days of receiving the requested documentation, provided the documentation is received within 45 calendar days of the date of the ADR.

For claims associated with any referrals to the ZPIC for program integrity investigation, MACs shall stop counting the 60-day time period on the date the referral is made. The 60-day time period will be restarted on the date the MAC received requested input from the ZPIC or is notified by the ZPIC that the referral has been declined.

For claims sent to MR for reopening by the contractor appeals department, in accordance with Pub. 100-04, chapter 34, §10.3, begin counting the 60 days from the time the medical records are received in the MR department.

Postpayment Review Requirements for Recovery Auditors

When a Recovery Auditor receives requested documentation for review within 45 calendar days of the date of the ADR, the Recovery Auditor shall do the following within 30 calendar days of receiving the requested documentation: 1) make and document the review determination, and 2) communicate the results to the provider.

Counting the 30 Calendar Day Timeframe

The MACs and Recovery Auditors shall count day one as the date each new medical record is received in the mailroom. The MACs and Recovery Auditors shall give each new medical record received an independent 30 day review time period.

Prepayment Review Requirements for ZPICs

When a ZPIC receives all documentation requested for prepayment review within 45 calendar days of the date of the ADR, the ZPIC shall make and document the review determination and notify the MAC of its determination within 60 calendar days of receiving all requested documentation.

State Laws that Affect Prepayment Review Timeliness Requirements

The MACs shall adhere to state laws that require an evidentiary hearing for the beneficiary before any denials are processed. The MAC shall review the claim within 30 days, allow the time required for the evidentiary hearing, and then continue with the processing of the claim on the next business day.

G. Auto Denial of Claim Line Item(s) Submitted with a GZ Modifier

Effective for dates of service on and after July 1, 2011, all MACs, PSCs and ZPICs shall automatically deny claim line(s) items submitted with a GZ modifier. Contractors shall not perform complex medical review on claim line(s) items submitted with the GZ modifier. The GZ modifier indicates that an ABN was not issued to the beneficiary and signifies that the provider expects denial due to a lack of medical necessity based on an informed knowledge of Medicare policy. All MACs shall make all language published in educational outreach materials, articles, and on their Web sites, consistent to state all claim line(s) items submitted with a GZ modifier shall be denied automatically and will not be subject to complex medical review. See Pub. 100-04, Medicare Claims Processing Manual, chapter 23, section 20.9.1.1. under paragraph F “GZ Modifier” for codes and the MSN to be used when automatically denying claim line(s) items submitted with a GZ modifier.