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# Medicare Peer Review Organization Manual

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HEALTH CARE FINANCING  
ADMINISTRATION (HCFA)

Department of Health and Human  
Services (DHHS)

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<u>HEADER SECTION NUMBERS</u>	<u>PAGES TO INSERT</u>	<u>PAGES TO DELETE</u>
1005-1015 (Cont.)	1-5 - 1-8 (4 pp.)	1-5 - 1-8 (4 pp.)
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## **NEW/REVISED MATERIAL--EFFECTIVE DATE: February 01, 2000**

Section 1010, PRO Responsibilities, **deletes** reference to program safeguard contractors. Peer Review Organizations (PROs) are not required to maintain Memoranda Of Agreements (MOAs) with program safeguard contractors. This section directs PROs to develop MOAs with assistants-at-cataract surgery. In addition, examples of notices of noncoverage have been provided. Further, in accordance with the Balanced Budget Refinement Act of 1999, this section **deletes** reference to waiver requests from Critical Access Hospitals (CAHs) to provide services beyond the 96 hour stay limitation.

Section 3000, Background, defines MOAs and directs PROs to develop MOAs with providers. PROs are not required to maintain MOAs with individual health care practitioners. Reference to Health Maintenance Organizations/Competitive Medical Plans has been deleted and replaced by Medicare+Choice (M+C) organizations.

Section 3001, Statutory Requirements for Agreements, **has been deleted**. Information formerly in this section has been incorporated in §3005.

Section 3002, Specifications, **has been deleted**. Information formerly in this section has been incorporated in §3015.

Section 3005, Statutory Authority for MOAs, provides information regarding the PROs' statutory authority to develop MOAs with providers, intermediaries, carriers, M+C organizations and State licensing/certification agencies.

Section 3010, Scope, provides general information about the types of activities PROs are required to perform under contract and directs PROs to include specific requirements regarding those activities in MOAs.

Section 3015, Provider MOA Specifications, contains revised information formerly in §3002 and describes minimum requirements of MOAs with providers of services.

Section 3020, MOAs With Specific Providers, contains specific requirements applicable to MOAs with M+C Organizations, assistants-at-cataract surgery, critical access hospitals (CAHs) and home health agencies. Incorporates language formerly in §4020 B regarding the use of an assistant-at-cataract surgery.

Section 3100, Introduction, further expands the definitions of intermediary and carrier.

Section 3105, Scope, provides general information regarding MOAs with intermediaries and carriers.

Section 3110, Intermediary/Carrier MOA Specifications, revised to describe minimum requirements PROs must include in developing MOAs with intermediaries and carriers.

### **Workload and Costs**

**These instructions do not represent any increase in workload or costs.**

**DISCLAIMER:** The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

Program Background and Responsibilities

## 1000. AUTHORITY

Peer Review Organization (PRO) review is governed by titles XI and XVIII of the Social Security Act (the Act) as amended, and by regulations contained in:

- o 42 CFR 405, 411 - Limitation on liability;
- o 42 CFR 412 - Outlier review, diagnosis related group (DRG) validation, and hospital notices of noncoverage;
- o 42 CFR 462 - Definition of eligible organizations and area designation;
- o 42 CFR 466 - Assumption and conduct of review;
- o 42 CFR 473 - PRO reconsideration and appeals;
- o 42 CFR 476 - Disclosure of information;
- o 42 CFR 482 - Hospital Conditions of Participation; and
- o 42 CFR 1004 - Sanctions.

## 1005. PURPOSE OF PRO REVIEW

You review items or services provided to Medicare beneficiaries to determine:

- o Whether services provided or proposed to be provided are reasonable and medically necessary for the diagnosis and treatment of illness or injury, or to improve functioning of a malformed body member, or (with respect to pneumococcal vaccine and mammograms) for prevention of an illness, or (in the case of hospice care) for the palliation and management of terminal illness;
- o Whether those services furnished or proposed to be furnished on an inpatient basis could be effectively furnished on an outpatient basis, or in an inpatient health care facility of a different type;
- o The medical necessity, reasonableness, and appropriateness of inpatient hospital care for which additional payment is sought under the outlier provisions of the prospective payment system (PPS);
- o Whether a hospital has misrepresented admission or discharge information, or has taken an action that results in the unnecessary admission of an individual entitled to benefits under Part A, unnecessary multiple admissions of an individual, or other inappropriate medical or other practices with respect to beneficiaries, or billing for services furnished to beneficiaries;
- o The validity of diagnostic and procedural information supplied by the provider to the intermediary for payment purposes;
- o The completeness and adequacy of hospital care provided; and
- o Whether the quality of services meets professionally recognized standards of health care.

These activities enable you to determine whether Medicare payment may be made for the services claimed and to identify and initiate corrective action where appropriate.

## 1010. PRO RESPONSIBILITIES

### A. Responsibilities Prior to Review.--You are responsible for:

o Obtaining written memoranda of agreements with all hospitals, critical access hospitals (CAHs), skilled nursing facilities (SNFs), home health agencies (HHAs), assistants-at-cataract surgery, Medicare+Choice (M+C) organizations, Clinical Data Abstraction Centers (CDACs), Medicare intermediaries and carriers, State agencies responsible for the licensing and certification of providers and practitioners in your jurisdiction, and other entities as directed by HCFA; (See Part 3).

o Specifying in your review plan and instructions to practitioners and providers the type of evidence you require to document that the care ordered or furnished was medically necessary, reasonable, and appropriate, and that the quality of services met professionally recognized standards of health care; and

o Applying professionally developed criteria for providing care, diagnosis, and treatment based upon typical patterns of practice within your geographic area to evaluate the medical necessity, quality, or appropriateness of services ordered or furnished.

### B. Ongoing Review Activities.--As a part of your ongoing review activities you must:

o Notify the appropriate agency of the State or Federal government when you become aware of situations which appear to be improper, but which do not fall within your review responsibilities (e.g., poor quality care in a renal dialysis center);

o Use your authority or influence to enlist the support of other professional or government agencies to ensure that all providers and practitioners for which you have review responsibilities comply with their obligations (see §1156 of the Act.); and

o Conduct beneficiary outreach and education activities for the express purpose of informing beneficiaries about:

- The PRO program and how to contact the PRO;
- Beneficiary rights as outlined at §1154(a)(4)(B) of the Act; and

- How to exercise those rights, including what to expect when they do contact the PRO (e.g., length of time to obtain a response, form the response will take). This information must include the processes regarding beneficiary complaints and notices of noncoverage (NONCs) (e.g., Hospital Issued Notice of Noncoverage and Notice of Discharge and Medicare Appeal Rights).

### C. Responsibilities as a Result of Your Review.--To act upon information you obtain as a result of your review activities you must:

o At least annually, publish and distribute to providers and practitioners, whose services you review, a report of your activities and findings as required in §1154(a)(6)(B) of the Act. It must include:

- A description of the types of cases where you have found inappropriate or unnecessary care, services that were rendered in an inappropriate setting, and/or services that did not meet professionally recognized standards of care; and

- A description of your Health Care Quality Improvement Program (HCQIP) activities.

o Identify and seek correction of situations that if continued, would result in violations under §1156 of the Act. This includes referring certain cases to State licensing boards. (See §1154(a)(9)(B) of the Act.);

o Submit reports to the Office of the Inspector General on providers and practitioners found to have substantially violated an obligation in a substantial number of cases, or to have grossly and flagrantly violated an obligation in one or more instances.; and

o Coordinate your activities, including information exchanges, in order to promote the efficient and economical operation of programs among appropriate public and private agencies. This fulfills §1154(a)(10) of the Act and includes, at a minimum:

- Meeting with the State agencies; and

- Communicating with accrediting bodies, quality organizations, and any other agencies as necessary to carry out PRO activities.

D. Additional Responsibilities.--Perform all other activities specified in the Statement of Work (SOW) of your HCFA contract, including any modifications, HCFA regulations and instructions, and relevant statutory provisions that include:

o Mandatory review activities (i.e., beneficiary complaints, violations of the Emergency Medical Treatment and Active Labor Act (EMTALA), assistants at cataract surgery, hospital requested higher-weighted DRG validation, hospital and M+C organization issued notices of noncoverage (e.g., Hospital Issued Notice of Noncoverage and Notice of Discharge and Medicare Appeal Rights), potential gross and flagrant violations, and referrals from HCFA, OIG, the M+C appeals contractor, intermediaries, carriers, CDACs or other designated HCFA contractors);

o Other legislatively mandated activities that include:

- Regional meetings with medical and administrative staff of the hospitals that you review;

- Onsite review activities at provider facilities that include 20 percent of the rural hospitals in your jurisdiction; and

o Additional activities approved by HCFA such as a special study (i.e., any effort within the scope of the services to be provided by a PRO in accordance with §1154 of the Act, which is not otherwise defined in the contract).

#### 1015. HEALTH CARE FINANCING ADMINISTRATION'S (HCFA'S) ROLE

HCFA was established in March 1977, to combine health care financing and quality assurance programs into a single agency. HCFA is responsible for the Medicare program, Federal participation in the Medicaid program, the Peer Review Organization (PRO) program, and a variety of other health care quality assurance programs.

A. The Primary Mission.--HCFA's primary mission is to administer its programs in a manner that:

- o Promotes the timely delivery of appropriate, quality health care to beneficiaries; o Ensures that beneficiaries are aware of the services for which they are eligible;
- o Ensures that those services are accessible and of high quality; and
- o Promotes efficiency and quality within the total health care delivery system.

B. Central Office Policy making Responsibility.--Overall Policy making responsibility for administration of the PRO program is centralized in HCFA's Office of Clinical Standards and Quality (OCSQ). OCSQ is responsible for:

- o Monitoring and overall administrative control of the PRO program, including coordinating with HCFA's Office of Internal Customer Support on contracts and financial aspects;
- o Establishing operational policy for the PRO program; and
- o Developing operational instructions and official interpretations of policy for PROs and HCFA regional offices (ROs).

C. Regional Office Assistance to PROs.--The ROs are responsible for assuring that PROs meet applicable Federal requirements under the provisions of their contracts. The ROs:

- o Provide liaison, direction, and technical assistance to PROs in the day-to-day management of their operations;
- o Interpret HCFA guidelines, policies, and procedures applicable to PRO activities;
- o Analyze PRO budgets and spending patterns to assure that funds are economically and appropriately utilized;
- o Recommend the allocation of funds for conducting additional activities;
- o Conduct assessments of PRO operations;
- o Review PRO actions; and
- o Provide feedback to each PRO.

## 1020. HEALTH CARE QUALITY IMPROVEMENT PROGRAM (HCQIP)

HCFA designed HCQIP to improve health outcomes of all Medicare beneficiaries regardless of personal characteristics (e.g., socio-economic status, health status, ethnic group), physical location (urban or rural), or setting (e.g., physicians' offices, Medicare+Choice (M+C) organizations, hospitals, nursing homes). Your Statement of Work sets forth specific quality indicators for national health improvement priorities which reflect the current state of PRO program experience, measurement systems, and data sources. These quality indicators do not address the entire spectrum of health care, nor do they reflect fully the unique circumstances of each State.

HCFA therefore requires you to conduct the following:

- o For Medicare beneficiaries in your State, implement quality improvement projects on a standardized set of quality indicators in each of the following six clinical topics: acute myocardial infarction, pneumonia, diabetes, breast cancer, stroke/transient ischemic attack/atrial fibrillation and congestive heart failure;

PART 3  
AGREEMENTS

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Memorandum of Agreement With Providers of Health Care Services

## 3000. BACKGROUND

The Memorandum of Agreement (MOA) is a written document which outlines your administrative and review responsibilities necessary to accomplish all review requirements under your contract (See §3005 for Statutory Authority Applicable to MOAs). PROs are required to develop, implement, and revise MOAs, acceptable to HCFA, with providers (See Glossary) of health care services as specified in the contract with the Secretary. In all instances, both the PRO and the provider are expected to honor the terms of the agreement. PROs are not required to develop MOAs with individual practitioners.

**NOTE:** PROs are not required to develop MOAs with individual physicians pertaining to physician services rendered in freestanding physician offices or physician offices related to Medicare +Choice (M+C) organization reviews.

## 3005. STATUTORY AUTHORITY FOR MOAs

The Social Security Act ( the Act) contains statutory provisions applicable to MOAs:

- o Section 1154(a)(1) gives you the authority to review services furnished by physicians, other health care practitioners, institutional and noninstitutional providers of health care services as specified in the contract with the Secretary.

- o Section 1154(a)(7)(C) states that you shall examine the pertinent records of any practitioner or provider of health care services that you have responsibility for review.

- o Section 1866 (a)(1)(E) of the Act requires providers of services to have an agreement with you to release data related to patients.

- o Section 1866(a)(1)(F)(i) of the Act requires hospitals which provide inpatient hospital services paid under the prospective payment system (PPS) to maintain an agreement with you to review the validity of diagnostic information provided by such hospital, the completeness, adequacy, and quality of care provided, the appropriateness of admissions and discharges, and the appropriateness of care provided.

- o Section 1866(a)(1)(F)(ii) of the Act requires other hospitals, Critical Access Hospitals (CAHs), Skilled Nursing Facilities (SNFs), and Home Health Agencies (HHAs) to maintain an agreement with the PRO to perform its functions.

- o Section 1876(i)(7)(A) of the Act requires each risk-sharing contract with an eligible organization to maintain a written agreement with you to review M+C organization services.

## 3010. SCOPE

MOAs are intended to facilitate the review process and to avoid any misunderstandings between you and the provider. Expectations regarding the following activities under the Scope of Work (SOW) should be outlined in your MOA:

A. Mandatory Case Review.--You are responsible for reviewing specific types of cases, including beneficiary complaints, hospital and M+C organization notices of noncoverage (e.g., Hospital Issued Notice of Noncoverage and Notice of Discharge and Medicare Appeal Rights), assistants at cataract surgery, diagnosis related group (DRG) changes, anti-dumping cases, CAH and/or utilization (payment) determinations by evaluating quality of care, the appropriateness of

admission/discharge, Medicare coverage issues, accuracy of coding or appropriateness of medical services. This is accomplished by the review procedures specified in Parts 4 and 5. The provider must provide you with the medical record in order for you to conduct these reviews. The results of these reviews may include denial of payment for admission, DRG changes, or confirmed quality of care concerns.

B. Health Care Quality Improvement--You are required to conduct quality improvement efforts to determine an opportunity to improve care based upon variation from accepted medical practice (derived from scientific research) and to work collaboratively with providers to improve the processes of care to improve upon this variance. You use information abstracted from medical records to accomplish this work. The provider is expected to provide all pertinent materials from the medical record for these efforts. (See Part 4.).

C. Payment Error Prevention Program--You are required to reduce the payment error rate for inpatient services under the prospective payment system (PPS) by initiating payment error prevention projects. The results of these efforts may include quality improvement efforts collectively developed by you and the provider of services, changes to DRG payment, educational efforts, or denial of payment. HCFA defines the inpatient PPS payment error rate as the number of dollars found to be paid in error out of the total of all dollars paid for inpatient PPS services. The number of dollars paid in error is defined as the absolute (or unsigned) difference between what was actually paid and what should have been paid as a result of review. Providers are expected to furnish the pertinent materials from the medical record in order to conduct these reviews.

### 3015. PROVIDER MOA SPECIFICATIONS

You are required to maintain an agreement with all providers. Examine all agreements currently in use in your review area and modify them to incorporate activities mentioned in the current SOW. Both parties should sign the modified MOA. An informational copy of the agreement should be provided to all providers subject to review within your review jurisdiction.

A. Elements of Agreement--MOAs with providers, should address all mandated activities under the SOW. At a minimum, MOAs must include the following elements (the elements listed are not all inclusive):

1. Medical Review--Review of medical services to determine whether the services were reasonable and medically necessary, were furnished in the appropriate setting, and were of a quality that meets professionally recognized standards of care;

**NOTE:** In hospital and M+C organization MOAs, include review requirements regarding notices of noncoverage (See Part 7.). In Ambulatory Surgical Center (ASC) and hospital MOAs, include the preadmission and preprocedure review requirements (e.g., assistants-at-cataract surgery). For additional information concerning assistants-at-cataract surgery see §3020 B, §3110 A.3., §3110 A.4. and § 4220.

2. Data Analysis--Review of individual patient care data furnished by providers to ensure the validity of all diagnostic and procedural information. Identify requirements that the provider agrees to comply with in providing necessary data and information;

3. Claims Analysis--Review payment data to determine whether payment may be made for services furnished (as appropriate);

4. Complaint Analysis--Review cases in response to written beneficiary complaints about the quality of services;

5. Confidentiality and Disclosure.--Include a Confidentiality and Disclosure Statement in accordance with § 1160 of the Act and 42 CFR Part 476;

6. Beneficiary Rights Outreach & Education Activities.--Conduct programs to inform Medicare enrollees about its review programs, the role of the PRO, grievance and complaint procedures;

7. Timing of Review.--Conduct review within the time frames specified in the contract;

8. Location of Review.--Specify where PRO review of cases will take place (i.e., at the PRO or hospital);

9. Work Space for Review Activities.--Address provisions of space for staff to conduct onsite review;

10. Corrective Action.--Develop, implement, and complete corrective action plans to address confirmed quality concerns or patterns of quality problems; and

11. Miscellaneous.--Identify additional review activities and procedures as prescribed by HCFA.

B. Required Signatures.--MOAs must be signed by representatives of your organization and appropriate provider representatives.

C. Modifying MOAs.--Modify MOAs when changes in the requirements of the SOW necessitate additional understandings between you and the provider. The revised MOA should be signed by representatives of your organization and representatives of the provider.

D. Failure to Honor the Terms of an MOA.--If you fail to reach an agreement with any provider regarding the provisions of the MOA, or if the provider fails to honor the provisions of an MOA, refer the circumstances to your project officer (PO) for resolution. HCFA reserves the right to determine if you made reasonable efforts to resolve the issue. If the provider continues to act outside the provisions of the MOA, the PO should contact the Regional Division of Medicaid and State Operations (DMSO). DMSO will investigate the infringement to determine if it violates the provisions of certification for Medicare payment.

If you fail to honor the provisions of the MOA, HCFA reserves the right to determine if this is a breach of your review responsibilities stipulated in your contract.

### 3020. MOAs WITH SPECIFIC PROVIDERS

A. Medicare+Choice (M+C) Organizations.--You are required to develop, implement and revise MOAs with M+C organizations outlining your administrative, review, and technical assistance/guidance responsibilities regarding quality assurance and performance improvement projects. It is the responsibility of the M+C organization to contact you to amend your current agreement. However, if there are new M+C organizations in the PRO area, you should contact the organization. The type of information contained in the MOA includes, but is not limited to the following:

- o Identifying an appropriate contact person for required activities;
- o Providing logistical information regarding the method, amount, and timing of how information will be transferred;
- o The process for Notices of Discharge and Medicare Appeal Rights (NODMARS);

**NOTE:** For purposes of NODMARS' immediate review, you are not required to have an agreement (to perform this review) with the M+C organization(s) in another state or in your own state if you do not have the Medicare contract with the M+C organization. Your MOAs with the hospitals in your review area will suffice. The PRO that has an agreement with the hospital treating the beneficiary must review the beneficiary's immediate review request.

- o Opportunities/methods to collaborate on quality improvement projects;
- o Procedures for obtaining records or copies of records (e.g., photocopying); and
- o The amount the PRO is to pay for photocopying and mailing records.

Include in the MOA any guidance or technical assistance you anticipate you will be able to provide. In addition, you may provide information on best practices and intervention materials that have been effective in your projects or abstraction tools. Refer to §3015 when developing your MOA with M+C organizations.

B. Assistants at Cataract Surgery.--In accordance with 42 CFR 466.78(a), you are required to maintain MOAs with hospitals and ambulatory surgical centers in the State. The MOA must provide for review of assistants-at-cataract surgery prior to service and for monitoring of the services billed on a postpayment basis. (See §3020 B, §3110 A.3., §3110 A.4. and § 4220).

C. Critical Access Hospitals.--Prior to the implementation of your review, develop MOAs with CAHs and the appropriate intermediary in your review area. Include specifications contained in §3015.

D. Home Health Agencies (HHAs).--Develop and implement MOAs with HHAs in your review area. You may develop one MOA with a parent HHA operating in a state that has a branch office or multiple branch offices located in the same state as the parent agency. Ensure that the name and address of all branch office locations are listed in the MOA with the parent agency. Separate MOAs with the respective State PRO are required for subunits of a parent HHA that are located in states different from that of the parent HHA. These HHA subunits are considered to be semi-autonomous organizations and must independently meet the conditions of participation for HHAs. (See 42 CFR 484.2).

In the event that a change of ownership occurs, the PRO must discuss the requirements of the current MOA with the new owner and obtain his/her signature before the MOA is assigned to the new owner.

Memorandum of Agreement With Payers of Health Care Services

## 3100. INTRODUCTION

An intermediary is a private insurance company that has entered into a contract with HCFA to process Medicare bills (claims) for Part A services performed by institutional providers. Carriers are private insurance companies that have contracted with HCFA to process beneficiary bills (claims) for Part B services, provided by noninstitutional providers. Carriers also handle claims for services by physicians. For purpose of this section, the terms payers refers to intermediaries and carriers. (See Glossary.)

MOAs are written documents that specify your administrative and review procedures necessary to accomplish all of your review requirements in you contract. Regulations at 42 CFR 466.80 require that each MOA be a negotiated agreement between you and the intermediary/carrier, and reflect mutually agreeable conditions necessary for data exchange requirements in recognition of the unique capabilities/requirements of each party. (See §3110.)

## 3105. SCOPE

You are required to develop, implement, and revise MOAs, acceptable to HCFA, with all appropriate intermediaries and carriers for Part A and Part B services. (See 42 CFR 466.80 (a).) You and the intermediary or carrier should identify the specific claims information you will communicate, the methods you will use to communicate that information and specify the role and responsibility of each party in communicating this information. Both you and the intermediary or carrier are expected to honor the terms of the agreement.

In addition, include in the MOA your expectations and the expectations of the intermediaries and carriers regarding Payment Error Protection activities. For example, PROs are not expected to make referrals to intermediaries for discharges that have not been reviewed but have been extrapolated from reviewed cases. PROs may extrapolate in order to develop educational or compliance program interventions, but only the intermediaries/carriers, OIG and the Department of Justice have the authority to extrapolate for purposes of recovering payments or imposing penalties. Roles and responsibilities regarding how payment adjustment and payment errors should be processed must be clearly defined in accordance with the SOW.

## 3110. INTERMEDIARY/CARRIER MOA SPECIFICATIONS

Examine all agreements currently in place and modify them to reflect current activities. Provide an informational copy of each agreement to all intermediaries and carriers in your review jurisdiction. You are expected to establish a separate MOA for intermediaries or carriers which service facilities in each state.

A. Elements of MOAs.--At a minimum, the MOAs with intermediaries/carriers should include the requirements mentioned in §3015 and the following elements below:

1. Claims Review.--Determine whether a provider or group of providers are furnishing noncovered or medically unnecessary services. Specify how you will receive any records subject to your review that are not provided directly by HCFA. The MOA must distinguish between hard copy and electronic submissions and reference the format for any electronic submission.

2. Data Review and Exchange.--Specify how you will receive records subject to your review that are not provided directly by HCFA. Provide for full compliance with HCFA requirements for the exchange of HCFA approved adjustment records and reconciliation of pending adjustment totals. Specify any physician or facility identifiers used by the intermediary other than the Medicare provider number and the intermediary code or Unique Physician Identification Number (UPIN);

3. Coordination.--Communicate program safeguards concerns or issues related to PRO activities. Ensure that the intermediary/carrier will provide you with as much advance notice as possible of significant fluctuations in the volume of processed claims. You must provide all appropriate internal contacts and procedures for resolving problems and exchanging any needed information or negotiating changes timely.

In reviewing Part A and B claims, you may determine that a surgical procedure was not necessary and that the physician portion of that services (Part B payment) may not be payable. Communicate this information to the intermediary and the carrier.

**NOTE:** PRO/CARRIER MOAs-In accordance with 42 CFR 466.80 maintain MOAs with each carrier processing cases you review. Include in the MOA a provision that payment will not be made for the use of an assistant-at-cataract surgery without prior approval (See §1866 (a)(15)(A) of the Act). Include provisions to establish a system to authorize payment and any other matters that are necessary for the coordination of the function.

4. Prepayment/Preprocedure Review.--Your request to intermediaries and carriers to implement preprocedure (e.g., assistant at cataract surgery) and prepayment review of a procedure, diagnosis, provider, or practitioner must conform with the negotiated MOAs between you and the payers outlining the conditions for necessary data exchange requirements. Comply with requirements for coordinated implementation of any HCFA-approved PRO prior authorization or prepayment review requirements. All MOAs should specify that when a provider submits a bill without your authorization, the bill will be submitted to you for prepayment review of the complete medical record. This includes physician notification of prior authorization billing requirements. You are responsible for the prepayment review system (PRS) implementation with the intermediary.

5. Notification of Denial and Reconsideration Determinations.--Provide for transmission of your denial letters to servicing payers and when necessary for medical review, copies of the medical records used. Include a negotiated processing time frame for your notification to the payers of denials, reconsideration reversals or modifications;

6. Information Exchange.--Include details for implementation of the following activities:

- Exchange of medical review policies;
- Quarterly meetings (which may be conference calls); and
- PRO review and comment on new carrier/intermediary policies for new technology.

B. Required Signatures.--MOAs must be signed by representatives of your organization and appropriate intermediary/carrier representatives.

C. Modifying an MOA.--Modify MOAs when changes in the requirements of the SOW necessitate additional understandings between you and the intermediary/carrier. The revised MOA must be signed by the appropriate parties.

D. Failure to Honor the Terms of an MOA.--The MOAs are written documents that specify your administrative and review procedures necessary to accomplish all of your review requirements. Both parties to an MOA (you and the Medicare payer) are expected to honor these agreements.

Notify your PO immediately if:

- o You are unable to reach an agreement with any payer;
- o A payer fails to comply with the terms of an existing MOA; or
- o You are unable to comply with the terms of an existing MOA.

HCFA reserves the right to determine if you made reasonable efforts to resolve the issue. If the intermediary/carrier continues to act outside the provisions of the MOA, the PO should contact staff in the Medicare contractor operations component of HCFA's Center for Beneficiary Services (CBS). CBS will investigate the infringement to determine if it violates the provisions of certification for Medicare payment.

If you fail to honor the provisions of the MOA, HCFA reserves the right to determine if this is a breach of your review responsibilities stipulated in your contract.