

Medicare Program Integrity Manual

Department of Health and
Human Services (DHHS)
CENTERS FOR MEDICARE &
MEDICAID SERVICES (CMS)

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CHANGE REQUEST 1891

CHAPTERS	REVISED SECTIONS	NEW SECTIONS	DELETED SECTIONS
1	Table of Contents		2.6
3	Table of Contents 4	4.1 4.1.1 4.1.2 4.1.3 4.1.4 4.2 4.3 4.4 4.5 4.6 4.7 4.8	
3	5 5.1 5.1.1 5.2		
3	6 6.1 6.2 6.3 6.4	6.5 6.6 6.7 6.8 6.9	
Exhibits		14.4	

NEW/REVISED MATERIAL--EFFECTIVE DATE: December 12, 2001

IMPLEMENTATION DATE: April 1, 2002

This transmittal changes the term "national coverage policy" to "national coverage determination" or "coverage provision in an interpretive manual" to be consistent with CR 1485.

Reorganizes chapter 3, sections 4, 5, and 6. Combines the terms "carrier" and "fiscal intermediary" into the term "contractor" throughout these sections. Removes reference to outdated MCM and MIM overpayment collection instructions and lists the more current CFR citations instead.

Chapter 1, §2.6 - Manual Review Personnel and Levels of Review -- is deleted and moved to Chapter 3, §4.5.

Chapter 3, §4 - Overview of Prepayment and Postpayment Review for MR Purposes -- Adds instructions to clarify that the requirements listed in this section (Section 4) apply only to reviews conducted for MR purposes. Requires contractors to notify providers that review has been initiated in certain circumstances.

Chapter 3, §4.1 - Determinations Made During Prepayment and Postpayment MR -- clarifies that contractors may make any or all of the determinations listed during claim review.. Describes how MR staff may be involved in assisting claims processing staff in making pricing determinations (making the PIM consistent with the PSC SOW).

Chapter 3, §4.1.1 - Documentation Specifications for Areas Selected for Prepayment or Postpayment MR - requires contractors to consider documentation submitted with claims during claim review except in case of medical impossibility and in cases where clear policy serves as the basis for the denial. Introduces a new term "development" whereby a contractor requests additional documentation after claim receipt. References the CFR requirements that certain tests must be ordered by the treating physician. References 1842(p)(1) which requires that all claims submitted by physicians and practitioners must contain ICD-9 diagnosis codes effective April 1, 2002. Requires that claims submitted by all other providers must contain ICD-9 diagnosis codes if such codes are required by LMRPs. Requires contractors to educate these providers about this new requirement.

Chapter 3, §4.1.2 - Additional Documentation Requests (ADR) During Prepayment or Postpayment MR -- Requires contractors to specify in an ADR those pieces of documentation needed. Clarifies that contractors may solicit documentation from third parties but only after soliciting and reviewing documentation from the billing provider. Requires contractors to notify the billing provider when they send an ADR to a third party. Requires contractors to notify providers that they have 30 days to respond to ADR requests (this will allow for adequate mailroom time) and gives contractors the discretion to grant an extension. Requires carriers to deny for lack of medical necessity when requested documentation is not received timely from the billing provider or third party. Manualizes the Progressive Corrective Action (PCA) PM requirement that contractor deny for failure to submit requested medical records by the 45th day unless an extension is granted. Allows contractors to reopen claims if late ADR responses are received within a reasonable number of days (generally 15) from the denial date. Clarifies when a denial can be counted as automated review when additional documentation was requested and not received.

Chapter 3, §4.1.3 - Completing Complex Reviews -- clarifies that for ADR responses that are received within the timeframe (or extended time frame) the contractor must complete the claims review within 60 days of receiving documentation.

Chapter 3, §4.1.4 - Handling Late Documentation -- clarifies how contractors should handle the receipt of late responses to ADRs.

Chapter 3, §4.2 - Denials -- adds a heading to existing language. Changes the term National Coverage Policy to National Coverage Determination. Clarifies that contractors do not have the option to "Return to Provider" for denial reasons listed but must deny the claim in full or in part. Requires contractors to indicate in the denial notice whether records were received. Adds a reference to Ruling 95-1 for further information on partial denials. When downcoding, requires contractors to retain a record of the submitted HCPCS code and modifiers. Reiterates that contractors must notify the beneficiary and provider if a claim is denied in full or in part. Requires contractors, effective March 1, 2001, to notify providers whether medical records were reviewed in those cases where a denial is made after an ADR was sent. Requires contractors to retain in

the audit trail of the claim record the procedure codes and modifiers that appeared on the original claim as submitted. Reiterates the importance of clearly distinguishing between benefit category, statutory exclusion, and reasonable and necessary denials and provides guidelines and examples.

Chapter 3, §4.3 - Documenting That A Claim Should Be Denied -- adds a heading to existing language.

Chapter 3, §4.4 - Internal MR Guidelines -- adds language describing internal MR guidelines (IMRGs). Requires contractors to make IMRGs available to internal staff. Prohibits contractors from using IMRGs to create or change policy.

Chapter 3, §4.5 - Types of Prepayment and Postpayment Review -- moves language from Chapter 1, §2.6 - Manual Review Personnel and Levels of Review. Revises the existing definitions of automated, routine, and complex reviews by clarifying that complex review involves any evaluation of medical records. Adds a requirement that contractors use at least LPNs to perform complex reviews (a 2001 BPR requirement). Adds a requirement that contractors demonstrate, upon request, that each complex review was performed by a clinician reviewer and that contractors maintain a credentials file on each clinician reviewer. Clarifies that clinician reviewers should use clinical judgement when making claim determinations. Requires contractors to charge appropriate contractor unit for MR reviews conducted for non-MR reasons. Clarifies when a denial should be counted as automated review when additional documentation was requested and not received. Adds examples to assist contractors in understanding the definitions of automated, routine, and complex review.

Chapter 3, §4.6 - Spreading Workload Evenly -- adds language instructing contractors to complete approximately 25 percent of their workload per quarter.

Chapter 3, §4.7 - New Provider / New Benefit Monitoring -- requires contractors to monitor through data analysis the billing patterns of new providers and new benefits. Directs contractors who choose to review new providers not to impose an administrative burden on the providers. Reminds contractors that although program savings are realized through denials for inappropriate provider billing, the optimal result occurs when providers no longer bill for non-covered or incorrectly coded services. Clarifies the requirement that "new benefits" means new legislative benefits, not new technology. New benefit edits should be continued until they no longer prove effective.

Chapter 3, §4.8 - Review That Involves Utilization Parameters -- Effective 7/1/02, prohibits contractors from denying services that exceed utilization parameters unless 1) clear policy serves as the basis for denial, 2) the denial is based on a medical impossibility, 3) the ADR response fails to support the coverage or coding of the claim, or 4) there is no timely response to an ADR.

Chapter 3, §5 – Prepayment Review of Claims for MR Purposes -- adds instructions to clarify that the requirements listed in this section (Section 5) apply only to reviews conducted for MR purposes unless otherwise noted. Reminds contractors that they do not have the authority to prohibit providers from submitting electronic claims.

Chapter 3, §5.1 - Automated Prepayment Review -- eliminates the term "egregious abuse" and adds "medical impossibility" as reasons to auto deny claims without reviewing attached documentation. Clarifies that fully automated review must have clear statute, NCD, coverage provisions in interpretive manuals, or LMRP that serve as the basis for denial, be based on medical impossibility or occur when no timely response is received in response to an ADR letter.

Chapter 3, § 5.1.1 -- Prepayment Edits -- adds subdivisions. Removes language that had allowed contractors to autodeney when egregious overutilization is detected. Waives requirements for contractors on the FISS system to focus edits in certain ways. Changes from quarterly to annually the frequency for conducting edit effectiveness reviews for most automated edits. Removes savings as a factor to be considered during the evaluation of edit effectiveness. Adds appeal staff time as a factor to consider during evaluation of edit effectiveness.

Chapter 3, §5.2 -- Categories of MR Edits -- Clarifies that once contractors have implemented the Comprehensive Error Rate Testing (CERT) program, they may no longer operate random edits.

Chapter 3, §6, Postpayment Review of Claims for MR Purposes – adds instructions to clarify that the requirements in Section 6 apply only to reviews conducted for MR purposes. {tc "6 – Postpayment Review of Claims"} Clearly delineate the steps involved in the postpayment review process and moves "adherence to reopening rules" up from §6.3.1.C.

Chapter 3, §6.1, Postpayment Review Case Selection -- clarifies that there are three types of postpay reviews: probe reviews, and statistical sampling reviews, and consent settlement review. Eliminates the term comprehensive medical review (CMR).

Chapter 3, §6.2, Location of Postpayment Reviews -- replaces the terms "On-Site" and "In-House" with the terms "Contractor Site" and "Provider Site." Clarifies that any contractor (not just FIs) may conduct provider site reviews at the contractor's discretion. Gives contractors the option (and eliminates the FI requirement) to use certified letter with return receipt when notifying providers that a postpay review is to begin. Changes the number of days to wait before denying for lack of medical records from 30 days to 45 days as required by PM AB-00-72. Extends to carriers and DMERCs the requirement to complete postpayment reviews within 60 days. Requires contractors to provide identification cards to all reviewers conducting provider site reviews. Requires contractors to educate providers that onsite review personnel will show ID cards upon arrival to the provider site.

Chapter 3, §6.3, Re-adjudication of Claims -- adds language that contractors re-adjudicate claims by making coverage, limitation of liability and/or coding determination in accordance with PIM Chapter 3, section 4.1. Changes the term National Coverage Policy to National Coverage Determination (NCD). Clarifies that in the absence of NCD, coverage provision in interpretive manual or local medical review policy the contractor may consider literature or knowledge of medical practice to guide their decision-making. Requires contractors to document instances of undercoding they detect. Adds a reference to Exhibit 14.4 for making liability determinations.

Chapter 3, §6.4, Estimate of the Correct Payment Amount and Subsequent Over/Underpayment -- clarifies that all contractors must net out the dollar amount of charges underbilled when calculating the overpayment amount.

Chapter 3, §6.5, Notification of Provider(s) and Beneficiaries of the Postpayment Review Results -- clarifies that contractors may issue a single letter that serves to both notify the provider of the review findings and demand the actual or estimated overpayment amount. Extends to all contractors the requirement that providers be notified upon completion of a postpayment review even when no overpayment was involved. Extends to all contractors the requirement to include total underpayment amount in the letter. Clarifies that beneficiaries must be notified when re-adjudication results in a change to the initial determination.

Chapter 3, §6.6, Provider(s) Rebuttal(s) of Findings -- extends to carriers the regulatory requirement that contractors notify providers of their right to submit a rebuttal of findings and consider such rebuttal before making a final decision. MR and Audit/Reimbursement (AR) staff should consider all of the evidence timely submitted to reach a determination regarding whether the determinations were incorrect and whether recoupment should be delayed.

Chapter 3, §6.7, Recovery of Overpayments -- Clarifies that the AR or overpayment staff may begin recovery the day the rebuttal period ends. Overpayment staff or AR staff shall recover all overpayments after making adjustments for any under-payments.

Chapter 3, §6.8, Evaluation of the Effectiveness of Postpayment Review and Next Steps -- Clarifies that contractors must determine if any other corrective actions are necessary as a result of postpay review. Revises the timeframe within which contractors are to perform a follow-up analysis of the provider(s) to determine if further corrective actions are required (to conform to the PCA PM AB-00-72). Clarifies that contractors may cease such monitoring if data analysis indicates resources would be better utilized elsewhere (to conform to the PCA PM AB-00-72).

Chapter 3, §6.9, Postpayment Files -- revised to require postpayment files to be retained for 7 years.

Exhibit 14.4, Effect of Sections 1879 and 1870 of the Social Security Act During Postpayment Reviews -- moves language from Chapter 3, §6.3.3.4 to an exhibit.

Redlining (red italic font) is used to indicate new material.

These instructions should be implemented within your current operating budget. Any adjustments need to your Medical Review Strategy must be negotiated with your regional office or Government Task Leader through the Supplemental Budget Request process.

Medicare Program Integrity Manual

Chapter 1 - Overview of Medical Review (MR) and Benefit Integrity (BI) and Medicare Integrity Program-Provider Education and Training (MIP-PET) Programs

Table of Contents
(REV. 17, 12-12-01)

2.6 - This section has been deleted

delete heading and all language at Chapter 1, §2.6

Chapter 3 - Verifying Potential Errors and Taking Corrective Actions

Table of Contents
(REV. 17, 12-12-01)

4 -- Overview of Prepayment and Postpayment Review for MR Purposes

4.1 – Determinations Made During Prepayment and Postpayment MR

4.1.1 -- Documentation Specifications for Areas Selected for Prepayment or Postpayment MR

4.1.2 – Additional Documentation Requests (ADR) During Prepayment or Postpayment MR

4.1.3 – Completing Complex Reviews

4.1.4– Handling Late Documentation

4.2– Denials

4.3 – Documenting That A Claim Should Be Denied

4.4 – Internal MR Guidelines

4.5 – Types of Prepayment and Postpayment Review

4.6 - Spreading Workload Evenly

4.7 - New Provider / New Benefit Monitoring

4.8 - Review That Involves Utilization Parameters

5 – Prepayment Review of Claims *For MR Purposes*

5.1 – Automated Prepayment Review

5.1.1 – Prepayment Edits

5.2 – Categories of MR Edits

6 – Postpayment Review of Claims *for MR Purposes*

6.1 – *Postpayment Review Case Selection*

6.2 – *Location of Postpayment Reviews*

6.3 – *Re-adjudication of Claims*

6.4 – *Estimate of the Correct Payment Amount and Subsequent Over/Underpayment*

6.5 – *Notification of Provider(s) and Beneficiaries of the Postpayment Review Results*

6.6 – *Provider(s) Rebuttal(s) of Findings*

6.7 – *Recovery of Overpayments*

6.8 – *Evaluation of the Effectiveness of Postpayment Review and Next Steps*

6.9 – *Postpayment Files*

4 – Overview of Prepayment and Postpayment Review for MR Purposes- (Rev. 17, 12-12-01)

The instructions listed in this section (Section 4) apply only to reviews conducted for MR purposes unless otherwise noted.

Prepayment MR of claims requires that a benefit category review, statutory exclusion review, reasonable and necessary review, and/or coding review be made BEFORE claim payment. Postpayment MR of claims requires that a benefit category review, statutory exclusion review, reasonable and necessary review, and/or coding review be made AFTER claim payment. These types of review allow the contractor the opportunity to make a determination to either pay a claim (in full or in part), deny payment or assess an overpayment.

A -- Provider Notification That Provider-Specific Prepay Review Or Any Kind Of Postpay Review Has Been Initiated

When initiating provider-specific prepay or any kind of postpay review (provider specific or service-specific), contractors must notify providers of the following:

- That the provider has been selected for review and the specific reason for such selection;*
- Whether the review will occur on a prepayment or postpayment basis;*
- If postpayment, the list of claims that require medical records;*

This notice must be in writing and must be separate from the Additional Documentation Request (ADR) letter. Contractors may (but are not required to) make this notification via certified letter with return receipt requested.

B -- Provider Notification That Service-Specific Prepay Review Review Has Been Initiated

When initiating service-specific prepay review, contractors must notify affected providers that the service has been selected for review and the specific reason for such selection. This notification must occur via an ADR letter. In addition, the contractor may include information on its website explaining that service-specific prepay review will be occurring and the rationale for conducting such review.

4.1 – Determinations Made During Prepayment and Postpayment MR - (Rev. 17, 12-12-01)

When carriers review claims, either on a prepayment or postpayment basis, they *may* make *any or all of the determinations listed below.*

Contractors must be able to differentiate the type of *determination made* to ensure that limitations on liability determinations are made when appropriate.

A -- Coverage Determinations

A claim may be covered, in full or in part, by a contractor if it meets all the conditions listed in PIM [Chapter 1, Section 2.3.3](#).

B -- Limitation of Liability Determinations

In accordance with [§1879 of the Act](#), contractors first consider coverage determinations based on the absence of a benefit category or based on statutory exclusion. If both these conditions are met, the next consideration should be whether the service was reasonable and necessary. Section 1862(a)(1) of the Act is the authority for denial because a service is not reasonable and necessary. When a claim is denied, in full or in part, because an item or service is not reasonable and necessary, contractors make and document [§§1879, 1870, and 1842\(1\)](#) (limitation of liability) determinations as appropriate. Because these determinations can be appealed, it is important that the rationale for the determination be documented both initially and at each level of appeal. Limitation of Liability determinations do not apply to denials based on determinations other than reasonable and necessary.

C -- Coding Determinations

See PIM [Chapter 1, Section 2.3.4](#) for a description of a coding determination.

D -- Pricing Determinations for First Time Not Otherwise Classified (NOC) Codes

In addition, contractor MR staff may assist contractor claims processing staff in making pricing determinations on NOC HCPCS codes. When the claims processing staff needs to price a payable NOC claim that requires medical knowledge to determine a correct price, the claims processing staff can suspend the service in question to an MR status location. The MR staff will review the information, gather any additional information (from the provider, medical literature, etc.), make a coverage, limitation on liability, coding, and potential fraud determination on the service. If the service is found to be payable, the MR staff will provide information needed to the claims processing staff so that they can price the service in accordance with HCFA pricing

methodologies described in the MCM and MIM. For frequently billed services, to the extent possible, contractors should keep track of these pricing determinations so that for future claims, the claims processing staff can price the claim using established MR pricing guidelines for that service.

4.1.1 -- Documentation Specifications for Areas Selected for Prepayment or Postpayment MR - (Rev. 17, 12-12-01)

The contractor may use any information they deem necessary to make a prepayment or postpayment claim review determination. This includes reviewing any documentation submitted with the claim as well as soliciting documentation from the provider or other entity when the contractor deems it necessary and in accordance with PIM Chapter 3, Section 4.1.2.

A -- Review of Documentation Submitted with the Claim

If a claim targeted for prepayment or postpayment review (including automated, routine, or complex) contains a modifier indicating that additional documentation is attached or was submitted simultaneously with an electronic claim, the contractor must review the documentation before denying the claim. There are two exceptions to this rule. Contractors may deny without reviewing attached or simultaneously submitted documentation (1) when clear policy serves as the basis for denial, and (2) in instances of medical impossibility (see PIM Chapter 3 §5.1).

NOTE: The term "clear policy" means a statute, NCD, coverage provision in an interpretive manual, or LMRP specifies the circumstances under which a service will always be considered non-covered or incorrectly coded.

B -- Review of Documentation Solicited After Claim Receipt

The process whereby a contractor requests additional documentation after claim receipt is known as "development." Providers selected for review are responsible for submitting medical records requested of them by the contractor within established timeframes. Development requirements are listed below in Section 4.2.1.

C -- Requirements That Certain Tests Must Be Ordered By The Treating Physician

[42 CFR 410.32\(a\)](#) requires that when billed to a carrier, all diagnostic x-ray tests, diagnostic laboratory test, and other diagnostic tests must be ordered by the physician who is treating the beneficiary for a specific medical problem and who uses the results in the management of the beneficiary's specific medical problem.

NOTE REGARDING LAB NEGOTIATED RULEMAKING: Contractors and providers should note that the requirements listed in section 4.1.1.C will be superceded on the effective date of a final rule revising [42 CFR 410.32](#).

D -- Diagnosis Requirements

Section 1833(e) of the Act provides that no payment may be made "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 . . ." Contractors may require information, in accordance with the requirements below whenever they deem necessary to make a determination listed in section 4.1 and thus to determine appropriate payment.

Some provider types are required to submit diagnosis codes on all claims while other provider types are required to submit diagnosis codes only if such information is required by an LMRP.

- ***Claims Submitted by Physicians or 1842(b)(18)(C) Practitioners Must Contain Diagnosis Codes***

Section 1842 (p)(1) states that each claim submitted by a physician or 1842(b)(18)(C) practitioner "shall include the appropriate diagnosis code (or codes)..." Services from physicians and 1842(b)(18)(C) practitioners may be denied as non-covered (not meeting benefit category requirements, statutorily excluded, or not reasonable and necessary) or as incorrectly coded if they are submitted without an ICD-9-CM code that supports coverage or correct coding.

- ***Claims Submitted By All Other Provider Types Must Contain Diagnosis Codes If Such Codes Are Required By An LMRP (effective 7/1/02)***

In order to address potential abuse or overutilization, contractors can require that ICD-9 diagnosis codes be submitted with each claim for the targeted service. This information is used in determining whether the services are covered and correctly coded. Effective April 1, 2002, contractors may require ICD-9 diagnosis codes to be submitted by all non-physician billers with every claim for a targeted service only if such a requirement appears in an LMRP for that service. Contractors must educate providers about this requirement beginning no later than January 1, 2002. This outreach should occur via website bulletin articles, etc.

For individual non-physician providers who are identified due to unusual billing practices, fraud referrals, etc., contractors may also request ICD-9 diagnosis codes to support the medical necessity of all or some claims submitted by the targeted entities, even if no LMRP exists requiring such codes.

For services submitted without ICD-9 diagnosis codes as indicated above, contractors should deny the claim, in full or in part, service as not reasonable and necessary.

E -- Requirements for Lab Claims

The American Medical Association's (AMA) 1998 edition of the Current Procedural Terminology (CPT) established three new and one revised Organ or Disease Oriented laboratory panels. Since these panels are composed of clinically relevant groupings of automated multichannel tests there is a general presumption of medical necessity. If there is data or reason to suspect abuse of the new panel codes, contractors may review these claims. Should contractors determine the need to develop a local medical review policy for laboratory

panel codes, develop these policies at the panel code level. In some instances of perceived abuse of the new panel codes, you may review the panel and deny component tests on a case-by-case basis or evaluate the need for the component level test.

4.1.2 – Additional Documentation Requests (ADR) During Prepayment or Postpayment MR- (Rev. 17, 12-12-01)

When contractors cannot make a coverage or coding determination based upon the information on the claim and its attachments, the contractors may solicit additional documentation from the provider by issuing an Additional Documentation Request (ADR). Carriers shall request additional information before deciding to deny or reduce an unassigned claim that is not reasonable and necessary. Contractors must ensure that all records requested are from the period under review.

Contractors must specify in the ADR the specific pieces of documentation needed (and ONLY those pieces needed) to make a coverage or coding determination. Contractors must follow the [Progressive Corrective Action program memorandum](#) (transmittal AB-00-72) in doing so.

A -- Development of Non-Lab Claims for Additional Documentation

If, during pre- or postpay review, a contractor chooses to send an Additional Documentation Request (ADR) regarding a targeted service, they must solicit the documentation from the **billing provider** and may solicit documentation from other entities (**third parties**) involved in the beneficiary's care. If a contractor chooses to solicit documentation from a third party, they may send the third party ADR simultaneously with the billing provider ADR. Contractors must send ADRs in accordance with the following requirements:

BILLING PROVIDER ADRs

- Contractors who choose to request additional documentation must solicit such information from the **billing provider** and must notify them that they have 30 days to respond. Contractors have the discretion to grant an extension of the timeframe upon request. For prepay review, the contractor must pend the claim for 45 days. Contractors may cc a third party.
- Contractors have the discretion to issue no more than 2 "reminder" notices via letter or phone call prior to the 45th day;
- If information is requested only from the **billing provider** and no response is received within 45 days after the date of the request (or extension), the contractor must deny the service as not reasonable and necessary. This would count as automated review.
- If information is requested only from the **billing provider** and the information received fails to support the coverage or coding of the claim, in full or in part, the contractor must deny the claim, in full or in part, using the appropriate denial code (see section 4.2). This would count as a complex review.

THIRD PARTY ADRs

A contractor may NOT solicit documentation from a **third party** unless the contractor first or simultaneously solicits the same information from the **billing provider**.

When a contractor solicits documentation from a third party:

- The contractor must notify the third party that they have 30 days to respond and copy the billing provider. Contractors have the discretion to grant extensions of the timeframe upon request.
- For prepay review, the contractor must pend the claim for 45 days. This 45 day time period may run concurrent with the 45 day time period for the billing provider ADR letter;
- Contractors have the discretion to issue more than 2 "reminder" notices via email, letter or phone call prior to the 45th day;
- If information is requested from **both** the billing provider and a third party and no response is received from either within 45 days after the date of the request (or extension), the contractor must deny the claim, in full or in part, as reasonable and necessary. This would count as automated review.
- If information requested from the **both** the billing provider and a third party and a response is received from one or both, but the information fails to support the coverage or coding of the claim, the contractor must deny the claim, in full or in part, using appropriate denial code (see Section 4.2)

B – Development of Lab Claims for Additional Documentation

Until the effective date of a final rule revising [42 CFR 410.32](#), contractors shall develop lab claims in accordance with the requirements listed in section 4.1.2.A above.

NOTE REGARDING LAB NEGOTIATED RULEMAKING: Contractors and providers should note that the requirements listed in section 4.1.2.B will be superceded on the effective date of a final rule revising 42 CFR 410.32.

4.1.3 – Completing Complex Reviews - (Rev. 17, 12-12-01)

A -- Medical Review Timeliness Requirement

For ADR responses that are received within the timeframe (or extended time frame) contractors must complete claims review and notify the provider and beneficiary, if indicated, within 60 days of receiving documentation.

B -- How to Count the 60 Days

- *For prepay reviews (e.g., prepay probe, regular prepay review) the contractor should begin counting with the receipt of each medical record. Each new medical record received should start a new 60 day clock.*
- *For postpay reviews (e.g., quality improvement reviews, OIG CFO, postpay probe, statistical sampling, etc.), contractors have the option of:*
 - *Beginning the counting with the receipt of each medical record. Each new medical record received would start a new 60 day clock, or*
 - *Waiting until all requested medical records are received and then start the 60 day clock.*

See section 4.2.C for description of the notification requirements.

4.1.4 Handling Late Documentation - (Rev. 17, 12-12-01)

Contractors Who Choose to Reopen -- *If a contractor receives the requested information after a denial has been issued but within a reasonable number of days (generally 15 days after the denial date), the contractor may **reopen** the claim. Contractors who choose to reopen must notify the provider of their intent, make a medical review determination, and notify the provider of the determination within 60 days of receipt of late documentaiton. The workload, costs, and savings associated with this activity should be allocated to the appropriate **MR** activity code in CAFM and PIMR (e.g., postpay complex).*

Contractors Who Choose NOT to Reopen -- *Contractors who choose not to reopen should not destroy the documentation but instead retain the information (hardcopy or electronic) in a location where it could be accessed by appeals staff and MR staff.*

4.2 – Denials - (Rev. 17, 12-12-01)

Contractors must deny claims, in full or in part, under the circumstances listed below. Contractors do not have the option to "Return To Provider" or reject claims under these circumstances. Contractors must deny the claim in full or in part. See [Ruling 95-1](#) for further information on partials denials (known as "downcoding").

A -- Denial Reasons Used for Reviews Conducted for MR or BI Purposes

Contractors must deny payment *on claims* either partially (e.g., by downcoding, or denying one line item on a multi-line claim) or in full whenever there is evidence that a service:

- *Does not meet the Benefit Category requirements described in Title XVIII of the Act and national coverage determination, coverage provision in interpretive manual, or LMRP and is not billed with a GY modifier;*
- *Is statutorily excluded by other than [§1862\(a\)\(1\)](#) of the Act and is not billed with a GY modifier;*

- Is not reasonable and necessary as defined under [§1862\(a\)\(1\)](#) of the Act *and is not billed with a GZ or GA modifier. (Contractors shall use this denial reason for all non-responses to ADRs)*
- Was not billed in compliance with the national and local coding requirements;

B -- Denials Reasons Used for Reviews Conducted for BI Purposes

Contractors must deny payment on claims either partially (e.g., by downcoding or denying one line item on a multi-line claim) or in full whenever there is evidence that a service:

- Was not rendered (or was not rendered as billed);
- Was furnished in violation of the self referral prohibition; or
- Was furnished, ordered or prescribed on or after the effective date of exclusion by a provider excluded from the Medicare program and that provider does not meet the exceptions identified below in PIM [Chapter 3, §11.2.6](#).

Contractors must deny payment whenever there is evidence that an item or service was not furnished, or not furnished as billed even while developing the case for referral to OIG or if the case has been accepted by the OIG. In cases where there is apparent fraud, but the case has been refused by law enforcement, contractors deny the claim(s) and collect the overpayment *where there is fraud- - after notifying law enforcement*. It is necessary to document each denial thoroughly to sustain denials in the appeals process. Intermediaries must make adjustments in cost reports, as appropriate.

C -- Denial Notices

If a claim is denied, in full or in part, the contractor must notify the beneficiary and the provider. The contractor shall include limitation of liability and appeals information. Notification can occur via Medicare Summary Notice (MSN) and Remittance Advice.

- ***Prepay Denial Messages***
Because the amount of space is limited, contractors need only provide high level information to providers when informing them of a prepayment denial via a remittance advice. In other words, the standard system remittance advice messages are sufficient notices to the provider. However, for routine and complex review, the contractor must retain more detailed information in a accessible location so that upon written or verbal request from the provider, the contractor can explain the specific reason the service was considered non-covered or not correctly coded.
- ***Postpay Denial Messages***
When notifying providers of the results of postpay medical review determinations, the contractor must explain the specific reason each service was considered noncovered or not correctly coded.

Indicate in the Denial Notice Whether Records Were Reviewed -- Effective March 1, 2002, for claims where the contractor has sent an ADR letter and no timely response was received,

contractors must indicate in the provider denial notice, using remittance advice code N102, that the denial was made without reviewing the medical record because the requested records were not received or were not received timely. This information will be useful to the provider in deciding whether to appeal the decision.

D -- Audit Trail

For reporting purposes, contractors need to differentiate automated, *routine and complex* prepayment review of claims. Contractor systems must maintain the outcome (e.g., audit trail) of prepayment decisions such as approved, denied, or partially denied. *When downcoding, contractors must retain a record of the HCPCS codes and modifiers that appeared on the original claim as submitted.*

See [PIM Exhibit 13.1](#).

E -- Distinguishing Between Benefit Category, Statutory Exclusion and Reasonable and Necessary Denials

Contractors must be very careful in choosing which denial type to use since Part A providers cannot appeal benefit category and statutory exclusion denials, and since beneficiaries' liability varies based on denial type. Benefit category denials take precedence over statutory exclusion and reasonable and necessary denials. Statutory exclusion denials take precedence over reasonable and necessary denials. Contractors should use the guidelines listed below in selecting the appropriate denial reason.

- If the contractor requests additional documentation from the provider or other entity (in accordance with PIM Chapter 3, Section 4.1.2.) for any MR reason (benefit category, statutory exclusion, reasonable/necessary, or coding), and the information is **not received** within 45 days, the contractor should issue a reasonable and necessary denial, in full or in part.*
- If the contractor requests additional documentation because compliance with a benefit category requirement is questioned and the contractor receives the additional documentation, but the evidence of the benefit category requirement is **missing**, the contractor should issue a benefit category denial.*
- If the contractor requests additional documentation because compliance with a benefit category requirement is questioned and the contractor receives the additional documentation which shows evidence that the benefit category requirement is **present but is defective**, the contractor should issue a reasonable and necessary denial.*

Example: A contractor is conducting a review of Partial Hospitalization (PH) services on a provider who has a problem with failing to comply with the benefit category requirement that there be a signed certification in the medical record. In the first medical record, the contractor finds that there is no signed certification present in the medical record. The contractor must deny all PH services for this beneficiary under [1835\(a\)\(2\)\(F\)](#) of The Act (a benefit category denial). However, in the second medical record, the contractor determines that a signed certification is present in the medical record, but the documentation does not support the physician's

certification, the services must be denied under [1862\(a\)\(1\)\(A\)](#) (a reasonable and necessary denial) because the certification is present but defective.

- *If a contractor performs routine review on a surgical procedure and determines that the procedure was cosmetic surgery and was not reasonable and necessary, the denial reason would be that the service is statutorily excluded since statutory exclusion denials take precedence over reasonable and necessary denials.*

4.3 - Documenting That A Claim Should Be Denied - (Rev. 17, 12-12-01)

For each claim denied, *or full or in part*, contractor MR or BI staff must carefully document the basis for the denial. If there are several reasons for denial, document each basis.

In establishing an overpayment, contractors carefully document claims for services not furnished or not furnished as billed so that the denials are more likely to be sustained upon appeal and judicial review.

4.4 - Internal MR Guidelines - (Rev. 17, 12-12-01)

As part of its process of reviewing claims, contractor MR may develop detailed written review guidelines ("Internal MR Guidelines.") Internal MR Guidelines, in essence, will allow the contractor to operationalize LMRPs and NCDs. Internal MR Guidelines shall specify what information should be reviewed by routine reviewers and the appropriate resulting determination. Contractor MR staff must make its Internal MR Guidelines available to their internal staff as needed (e.g., the appeals unit, phone inquiry unit, etc.). Internal MR Guidelines must not create or change policy.

4.5 - Types of Prepayment and Postpayment Review - (Rev. 17, 12-12-01)

Claim review activities are divided into three distinct types of review:

A -- Automated Prepayment Review

When prepayment review is automated, decisions are made at the system level, using available electronic information, without the intervention of contractor personnel. See Section 5.1 for further discussion of automated prepayment review.

B -- Routine Prepayment/Postpayment Review

Routine prepayment review requires the intervention of specially trained MR staff. An intervention can occur at any point in the review process. For example, a claim may be *suspended* for *routine* review because an MR determination cannot be *automated*.

- *Routine review requires hands-on review of the claim and/or any attachment submitted by the provider (other than medical records) and/or claims history file and/or internal MR guidelines.*

C -- Complex Prepayment/Postpayment Review

Complex review goes beyond the routine review process to include the evaluation of medical records or any other documentation the review of which requires professional medical expertise, including for example, ambulance trip reports for the purpose of preventing or identifying payments of non-covered or incorrectly coded services. Only clinician reviewers may perform MR-directed and BI-directed complex review (i.e., review that involves any evaluation of medical records) for the purpose of making a coverage or coding determination. For example, if a reviewer in the claims processing unit has been tasked with conducting review of ambulance medical records and trip reports for the purpose of making a coverage determination, that reviewer must be a clinician reviewer. Any review that includes medical records (i.e., looking at medical records for the presence or absence of required documentation such as a particular ICD-9 code or plan of care) is considered complex review and must be performed by a clinician.

A clinician reviewer is a nurse (LPN or RN) or physician reviewer. Only CMS Central Office staff may waive this requirement, must do so in writing, and any such waiver may be for no more than 12 months duration. Experienced nurse reviewers and physician reviewers generally need less detailed instructions than first and second level claims reviewers. In order to ensure that complex reviews are only performed by clinicians, contractors may be asked to demonstrate that all complex reviews (including reviews conducted by temporary staff) have been performed by a clinician. Contractors must maintain a credentials file for each reviewer who performs one or more complex reviews (including consultants, contract staff, subcontractors, and temporary MR staff). The credentials file must contain at least a copy of the reviewer's professional license.

Both nurse and physician reviewers may call upon other health care professionals (e.g., physical therapists, dieticians, and physician specialists) for advice. Any determination by a clinician must be documented and include the rationale for the decision. While clinicians must also follow NCD and LMRPs, they are expected to interpret ambiguous or "gray" areas not addressed by LMRP or NCD, and when necessary, evaluate the appropriateness of the service. Clinician reviewers must use their expertise to make clinical judgements when making medical review determinations. They must take into consideration the clinical condition of the beneficiary as indicated by the beneficiary's diagnosis and medical history when making these determinations. For example, if a medical record indicates that a beneficiary is a few days post-op for a total hip replacement and femur plating, even though the medical record does not specifically state that the beneficiary requires the special skills of ambulance transportation, clinician reviewers must use their clinical knowledge to conclude that ambulance transportation is appropriate under such circumstances.

Complex medical review performed by medical review staff for purposes other than MR (for example, for benefit integrity investigations or for appeals) should be charged for expenditure reporting purposes to the area requiring medical review services.

D -- Examples

The following examples are provided to assist contractors in understanding the definitions of automated, routine, and complex review.

Example 1: A contractor sets up the system so that for a particular HCPCS/ICD9 combination, the computer will request documentation, suspend for manual review, and auto-deny in 45 days if no documentation is received. For claims where no documentation is received within 45 days, the computer auto-denies the claim without

manual intervention. Even though the contractor intended to perform manual review, because they ACTUALLY performed automated review, this review should be counted a AUTOMATED.

Example 2: *A contractor sets up the system so that for a particular HCPCS/ICD9 combination, the computer will suspend for routine review. During routine manual review, the reviewer determines that complex review is needed and initiates a request for additional documentation. For claims where no documentation is received within 45 days, the computer denies the claim. Because the contractor ACTUALLY performed routine manual review, this claim should be counted as ROUTINE review.*

Example 3: *A contractor sets up the system so that for a particular HCPCS/ICD9 combination, the computer will suspend for routine manual review. During routine manual review, the reviewer determines that complex review is needed and initiates a request for additional documentation. For claims where documentation is received, the clinician reviews the documentation and makes a decision. Because the HIGHEST LEVEL of review the contractor performed was complex manual review, this claim should be counted as COMPLEX review.*

4.6 Spreading Workload Evenly (Rev. 17, 12-12-01)

The type and amount of workload a contractor must perform each year is specified in their MR Strategy or Statement of Work (SOW).

All types of prepayment and postpayment review must be performed each and every month (unless otherwise specified in an applicable SOW). Furthermore, to prevent "bunching" contractors should complete approximately 25 percent of their workload per quarter.

4.7 -- New Provider/ New Benefit Monitoring - (Rev. 17, 12-12-01)

Contractors must monitor through data analysis the billing patterns of new providers and for new statutory benefits to ensure correct coverage and coding from the beginning. Contractors have the option of performing prepay or postpay review of new providers as needed. Where contractors choose to perform pre or postpay review of a new provider, the contractors should perform only limited review (i.e., 20-40 claims) in order to ensure accurate billing. The sample size should not impose an administrative burden or significantly impact on the provider's cash flow. New benefit edits should be continued until they no longer prove effective or until the contractor determines that resources would best be spent on other types of review.

Note: *While program savings are realized through denials for inappropriate provider billing, the optimal result occurs when providers no longer bill for non-covered or incorrectly coded services.*

4.8 - Review That Involves Utilization Parameters - (Rev. 17, 12-12-01)

A -- General

During any type of MR-directed review (prepay or postpay; automated, routine or complex), contractors shall not deny services that exceed utilization parameters unless:

- 1. clear policy serves as the basis for the denial,*

2. *the denial is based on **medical impossibility** (e.g., 10,000 blood cultures for the same beneficiary on the same day),*
3. *the contractor sent an ADR letter and reviewed the ADR response but the **ADR response failed to support** the coverage or coding of the claim, or*
4. ***no timely response** is received in response to an ADR letter.*

NOTE: The term "clear policy" means a statute, NCD, coverage provision in an interpretive manual, or LMRP specifies the circumstances under which a service will always be considered non-covered or incorrectly coded. Clear policy that will be used as the basis for frequency denials must contain utilization guidelines that the contractor considers acceptable for coverage. Definitions of utilization guidelines and parameters can be found in [PIM Chapter 1, Section 2.5](#).

B -- Automated vs. Complex Review Involving Utilization Parameters

Contractors should **always** seek to implement prepayment edits that will prevent payment of services to providers billing egregious amounts and/or to providers with a pattern of billing for services that are not covered. When contractors identify egregious overutilization *within the context of their MR Strategy and prioritization of review targets*, they must respond timely.

- When *overutilization is identified and clear policy serves as the basis for denial*, contractors may *establish edits to automatically* deny the *services*.
- When overutilization is identified and there is **not** clear *policy to serve as the basis for denial*, contractors must quickly establish **complex** review edits and make individual claim determinations. *Contractors must develop for additional documentation in these situations.*

If the overutilization problem is determined to be widespread, the contractor should follow the requirements in the [Progressive Corrective Action program memorandum](#) (transmittal AB-00-72)

5 – Prepayment Review of Claims For MR Purposes- (Rev. 17, 12-12-01)

The instructions listed in this section (Section 5) apply only to reviews conducted for MR purposes unless otherwise noted.

Contractors may not prohibit providers from submitting electronic claims, even those providers who have been selected for prepayment review.

5.1 – Automated Prepayment Review - (Rev. 17, 12-12-01)

When prepayment review is automated, decisions are made at the system level, using available electronic information, without the intervention of contractor personnel. When appropriately implemented, automated review increases efficiency and consistency of decisions. Contractors must implement automated prepayment review whenever appropriate.

Automated review must:

1. *have **clear policy*** that serves as the basis for denial,
2. *be based on **medical impossibility** (e.g., hysterectomy for a male), or*
3. *occur when **no timely response** is received in response to an ADR letter.*

When a *clear policy exists or in the case of medical impossibility*, contractors may automatically deny the services without stopping the claim for *routine or complex* review, **even if documentation is attached**. Reviewers must still make a §1879 limitation on liability determination *which* may require *routine* review. *If additional documentation has been requested for a claim and the information has not been received within 45 days, the denial can be counted as an automated review if there was no human intervention. If human intervention occurs, the denials are counted as routine review.*

NOTE: The term "clear policy" means a statute, NCD, coverage provision in an interpretive manual, or LMRP specifies the circumstances under which a service will always be considered non-covered or incorrectly coded.

5.1.1 – Prepayment Edits - (Rev. 17, 12-12-01)

Prepayment edits are designed by contractor staff and put in place to prevent payment for noncovered and/or incorrectly coded services and to select targeted claims for review prior to payment. MR edit development is the creation of logic (the edit) that is used during claims processing prior to payment that validates and/or compares data elements on the claim.

A -- Ability to Target

Contractors must focus edits, to the extent possible, to suspend only those claims with the greatest likelihood of being denied and avoid suspending claims of providers who have not contributed to the problem. Focusing edits to target claims minimizes inefficient review and provider hassle. *The edits should be specific enough to identify only the services that the contractor determines to be questionable based on data analysis.* Prepayment edits must be able to key on a beneficiary's Health Insurance Claim Number (HICN), a provider's identification (e.g., Provider Identification Number (PIN), UPIN) and specialty, service dates, and medical code(s) (i.e., HCPCS and/or ICD-9 diagnoses codes). Intermediary edits must also key on Type Of Bill (TOB), revenue codes, occurrence codes, condition codes, and value codes.

Carrier systems must be able to perform several comparisons to select claims for prepayment review. By January 2001 (*unless otherwise specified*), FI systems must be able to perform these comparisons as well. At a minimum, those comparisons must include:

- Procedure to Procedure – This relationship permits contractor systems to screen multiple services at the claim level and in history. *Intermediaries on the FISS system are waived from this requirement until the FI Standard System is updated to include this capability.*
- Procedure to Provider – For a given provider, this permits selective screening of services that need review.

- Frequency to Time – This allows contractors to screen for a certain number of services provided within a given time period. *Intermediaries on the FISS system are waived from this requirement until the FI Standard System is updated to include this capability.*
- Diagnosis to Procedure – This allows contractors to screen for services submitted with a specific diagnosis. For example, the need for a vitamin B12 injection is related to pernicious anemia, absence of the stomach, or distal ileum. Contractors must be able to establish edits where specific diagnosis/procedure relationships are considered in order to qualify the claim for payment.
- Procedure to Specialty Code (Carrier) or TOB (Intermediary) – This permits contractors to screen services provided by a certain specialty or type of bill.
- Procedure to Place of Service – This allows selective screening of claims where the service was provided in a certain setting such as a comprehensive outpatient rehabilitation facility.

Examples of intermediary edits include, but are not limited to, the following:

- Diagnoses alone or in combination with related factors, e.g., all ICD-9-CM codes XXX.X-XXX.X with revenue code (REV) XXX and units greater than X;
- Revenue and/or HCPCS codes, e.g., a REV with a selected HCPCS (REV XXX with HCPCS XXXXX);
- Charges related to utilization, e.g., an established dollar limit for specific REV or HCPCS (REV XXX with HCPCS XXXXX with charges over \$500);
- Length of stay or number of visits, e.g., a selected service or a group of services occurring during a designated time period (bill type XXX with covered days/visits exceeding XX); and
- Specific providers alone or in combination with other parameters (provider XX-XXXX with charges for REV XXX).

B -- Evaluation of Prepayment Edits

Development or retention of edits should be based on data analysis, identification, and prioritization of identified problems. The contractor must evaluate all service specific and provider specific prepayment edits *as follows:*

- *New automated edits must be evaluated (and adjusted as needed) quarterly until they prove effective.*
- *Established automated edits must be evaluated annually.*
- *All edits that result in routine or complex review must be evaluated quarterly.*

The purpose of this evaluation is to determine their continuing effectiveness and contribution to workload. Contractors shall consider an edit to be effective when an edit has a reasonable rate of denial relative to suspensions and a reasonable dollar return on cost of operation or potential to avoid significant risk to beneficiaries. Revise or replace edits that are determined to be ineffective. Edits may be ineffective when payments *or claims* denied are very small in proportion to the volume of claims suspended for review. It is appropriate to leave edits in place if sufficient data are not available to evaluate effectiveness, if a measurable impact is expected, or if a quarter is too short for change to occur. Contractors should analyze prepayment edits in conjunction with data analysis to confirm or re-establish priorities. Contractors should replace, if appropriate, existing effective edits to address problems that are potentially more costly.

FACTORS *CONTRACTORS MUST* CONSIDER IN LOOKING AT EDIT EFFECTIVENESS FOR *ESTABLISHED AUTOMATED EDITS*:

- *Time and staff needed for review, including appeals reviews. Contractors must implement mechanisms (e.g., manual logs, automated tracking systems) to allow the appeals unit to communicate to the MR unit information such as which denial categories are causing the greatest impact on appeals, the outcome of the appeal, etc. Contractors must maintain and make available to RO and CO staff documentation demonstrating that they consider appeals in their edit evaluation process; and*
- *Specificity of edits in relation to identified problem(s).*

Contractors should note that even an automated edit that results in no denials may be considered an effective edit so long as the presence of the edit is not preventing other automated edits from being installed.

FACTORS *CONTRACTORS MUST* CONSIDER IN LOOKING AT EDIT EFFECTIVENESS FOR *ALL OTHER EDITS*:

- *Time and staff needed for review, including appeals reviews. Contractors must implement mechanisms (e.g., manual logs, automated tracking systems) to allow the appeals unit to communicate to the MR unit information such as which denial categories are causing the greatest impact on appeals, the outcome of the appeal, etc. Contractors must maintain and make available to RO and CO staff documentation demonstrating that they consider appeals in their edit evaluation process.*
- *Specificity of edits in relation to identified problem(s);*
- *Demonstrated change in provider behavior, e.g., the contractor can show the decrease in frequency of services per beneficiary, the decrease in the number of beneficiaries receiving the services, the service is no longer billed, or another valid measure can be used to reflect a change in provider behavior over time;*
- *Impact of educational or deterrent effect in relation to review costs; and*
- *The presence of more costly problems identified in data analysis that needs higher priority than existing edits **considering the** number of claims/days/charges reviewed in comparison to claims/days/charges denied;*

Contractors must test each edit before implementation to determine the impact on workload and whether the edit accomplishes the objective of efficiently selecting claims for review.

5.2 – Categories of MR Edits - (Rev. 17, 12-12-01)

Because it is important to have the flexibility to modify MR edits based on workload demands and changes in provider behavior, contractors are encouraged to ensure that *most* MR edits are located in the table driven portion of the system and are not hard coded.

For reporting purposes, there are three kinds of prepayment edits:

A -- Service-Specific Edits

These are edits that select claims for specific services for review. They may compare two or more data elements present on the same claim (e.g., diagnosis to procedure code), or they could compare one or more data elements on a claim with data from the beneficiary's history file (e.g., procedure code compared to history file to determine frequency in past 12 months).

B -- Provider-Specific System Edits

These are edits that select claims from specific providers flagged for review. These providers are singled out due to unusual practice patterns, knowledge of service area abuses, and/or utilization complaints received from beneficiaries or others. These edits can suspend all claims from a particular provider or focus on selected services, place of service, etc. (e.g., all claims for holter monitoring from a given provider).

C -- Random Edits

Once contractors have implemented the Comprehensive Error Rate Testing (CERT) program, they may no longer operate any random edits.

6 – Postpayment Review of Claims{tc "6 – Postpayment Review of Claims"} *for MR Purposes* (Rev. 17, 12-12-01)

The instructions listed in this section (Section 6) apply only to reviews conducted for MR purposes unless otherwise noted.

Postpayment claims review occurs when a contractor makes a coverage or coding determination after a claim has been paid. This section describes the requirements that contractors must follow when conducting postpayment claims review for MR purposes. Contractors who are reviewing claim on a postpayment basis for potential fraud case development purposes are not required to follow these requirements.

A -- Major Steps

There are nine major steps in the postpayment review process:

Step 1: Selecting the Cases for Review (see PIM Chapter 3, Section 6.1)

Step 2: Deciding the Location of the Review (See PIM Chapter 3, Section 6.2)

Step 3: Re-Adjudicating the Claims (See PIM Chapter 3, Section 6.3)

Step 4: Estimating the Over/Underpayment (See PIM Chapter 3, Section 6.4)

Step 5: Notification of Review Results (See PIM Chapter 3, Section 6.5)

Step 6: Considering/Responding to a Provider's Rebuttal (See PIM Chapter 3, Section 6.6)

Step 7: Recovering the Overpayment (See PIM Chapter 3, Section 6.7)

Step 8: Evaluating Postpay Review and Next Steps (See PIM Chapter 3, Section 6.8)

Step 9: Maintaining Files (See PIM Chapter 3, Section 6.9)

If at any point in these steps a contractor detects potential fraud, the contractor should not take any further steps in the process but should follow the instructions in section 6.8.

B -- Adherence to Reopening Rules { "6.3.1 – Adherence to Reopening Rules" | 3 }

When conducting a postpayment review, contractors must adhere in all cases to reopening rules. (See [42 CFR 405.750](#); [20 CFR 404.988\(b\)](#) and [404.989](#)).

6.1 – Postpayment Review Case Selection (Rev. 17, 12-12-01)

Postpayment reviews are usually targeted to providers, whether individuals or groups, who have demonstrated aberrant billing and/or practice patterns. However, some postpay reviews (e.g. widespread probes) may involve multiple providers.

Contractors must use all available relevant information when selecting postpayment review cases. See PIM [Chapter 3, Section 2](#) for Verifying Potential Errors and Setting Priorities)

There are three types of postpayment reviews:

- *Error Validation reviews, also known as "probe" reviews (see PIM [Chapter 3, Section 2](#) for more information about probe reviews), and*
- *Statistical Sampling reviews (see 6.1.2 below).*
- *Consent Settlement reviews (see PIM, [Chapter 3, Section 8.3.3](#))*

NOTE: *In the process of selecting providers for postpay review, MR staff should review the PTS and consult with the BI unit to ensure duplicate efforts are not being undertaken. (See PIM [Chapter 3, Section 1.2](#).)*

A -- Identifying Providers for Error Validation Reviews

PIM [Chapter 3, Section 2](#) describes the requirements regarding which providers should be selected for error validation (probe) review.

B -- Identifying Providers for Statistical Sampling Reviews

The first step in conducting a statistical sampling review is the identification of all services under review from the provider or group of providers for the specified time period (this is termed the "universe") followed by selection of a sample of these claims. Contractors work with their statistical staff and follow all statistical sampling guidelines in PIM [Exhibits 7](#) through [7.7](#) as well as [transmittal B-01-01](#).

Case selection is based on profiling providers who have generated one or more assigned claims during the period under review. Intermediaries use provider numbers and carriers use UPINs for physicians and individual PINs for non-physicians. DMERCs should use the NSC issued supplier numbers. As with physician UPINs and PINs, it may be appropriate to analyze suppliers by their six-digit base number and their 10-digit (six-digit base plus four-digit) location ID number. It may be necessary to conduct sub-studies of locality practices for physicians using their PINs because physicians with one UPIN may have different practices with multiple PINs. Their patterns of practice may vary across different locations (e.g., hospital-based, office-based, SNF-based), especially when physicians designate different specialties for their different PINs.

6.2 – Location of Postpayment Reviews{tc "6.2.2 – Location of SVRS Reviews" \l 3} (Rev. 17, 12-12-01)

This section applies to all three types of postpayment reviews (error validation reviews, statistical sampling reviews, and consent settlement reviews).

Contractors must decide whether to conduct the postpay review at the provider site or at the contractor site. Considerations in determining whether to conduct a provider-site review are:

- The extent of aberrant patterns identified in their focused review program; (See PIM [Chapter 3, Section 2](#).)*
- The past failure of a provider to submit appropriate and timely medical records; and*
- Contractor resources.*

A -- Contractor Site Reviews{tc "6.2.2.1 – Contractor Site Reviews" \l 4}

The contractor notifies the provider(s) that they have 30 calendar days from the date of the letter to provide the medical record or other requested documentation. (See PIM [Exhibit 7.5](#) for a sample letter.) Contractors have the discretion to grant an extension of the timeframes upon request.

If the information requested is not received within 45 days, the contractor shall review the claims with the information on hand. Contractors must complete the review and notify the provider in writing of their findings within 60 calendar days from the start of the review, or receipt of medical records, whichever is later. If the contractor needs more than 60 calendar days, they must request an extension from the RO. (see PIM Exhibits [7.6](#) or [7.7](#))

B -- Provider Site Reviews{tc "6.2.2.2 – Provider Site Reviews" \l 4}

Contractors determine what, if any, advance notification of a scheduled review is given to a provider. The contractor may give advance notice when a provider has satellite offices from which medical records will have to be retrieved. When giving advance notice, the contractor must include an explanation of why the review is being conducted.

The list of claims requiring medical records may be included with the advance notice or at the time of the visit at the discretion of the contractor.

Contractors may conduct team reviews when potential problems exist in multiple areas. The team may consist of MR, audit, fraud, State surveyors, provider enrollment or Medicaid staff depending on the issues identified. As a minimum, before conducting provider site reviews, consult and share information with other internal and external staff as appropriate to determine if there are issues that the reviewers should be aware of or if a team review is needed.

Contractors may contact selected beneficiaries.

Annually, contractors must instruct providers (via bulletin article, web article, etc.) that any Medicare contractor staff person who visits the provider site must show a photo identification indicating their affiliation with the Medicare contractor. Contractors must provide to all reviewers who participate in provider site reviews a photo identification card indicating the reviewer's affiliation with the Medicare contractor. Upon arrival to the provider site, the reviewer must show this photo identification card to the provider staff.

During provider site reviews, reviewers shall photocopy pertinent medical records when services are denied, when a physician or other medical consultation is needed, or when it appears that records have been altered. Contractors shall retain these records for appeals or BI purposes.

Reviewers shall hold entrance and exit interviews with appropriate provider staff. A provider representative can also be present while claims are reviewed. Reviewers must answer any questions the provider staff may have.

During entrance interviews, reviewers explain the following:

- Scope and purpose of the review*
- Why postpayment review is being conducted*
- The list of claims that require medical records*
- How recoupment of overpayment is made if claims are denied,*
- Answer any questions related to the review, and*
- Notify the provider of their rebuttal rights (See PIM, Chapter 3, Section 6.6)*

During exit conferences, the contractor shall discuss the findings of the review. The provider must be allowed an opportunity to discuss or comment on the claims decisions.

6.3 – Re-adjudication of Claims (Rev. 17, 12-12-01){tc "6.2.3 – Conducting the SVRS" \l 3}

This section applies to all three types of postpayment reviews (error validation reviews, statistical sampling reviews, and consent settlement reviews).

For each claim in the sample, contractors re-adjudicate claims by making a coverage, limitation of liability and/or coding determination in accordance with PIM Chapter 3, Section 4.1. Contractors must document all items/services incorrectly paid, denied or undercoded (e.g., billed using a HCPCS or other code that is lower than what is supported by the medical record). They report services newly denied as a result of re-adjudication as positive values and they report services that were denied but are reinstated as a result of re-adjudication as negative values. Contractors document the amount of the over/underpayment and how it was determined. Intermediaries must do this in conjunction with Audit/Reimbursement staff. (See PIM [Chapter 3, Section 8](#).) Contractors must assure that their documentation is clear and concise and includes the basis for revisions in each case (this is important for provider appeals). They include copies of the NCD, coverage provision in interpretive manual or LMRP and any applicable references needed to support individual case determinations. Compliance with these requirements facilitates adherence to the provider notification requirements in PIM Chapter 3, Section 6.2.3D and Section 6.5.

6.4 – Estimate of the Correct Payment Amount and Subsequent Over/Underpayment (Rev. 17, 12-12-01){tc "6.8 – Estimate of the Correct Payment Amount and Subsequent Over/Underpayment" \l 2}

This section applies to all three types of postpayment reviews (error validation reviews, statistical sampling reviews, and consent settlement reviews).

The results of the re-adjudication within the sampling units are used to determine the total overpayment amount for each provider under review. MR must refer to instructions in PIM [Exhibits 9, 10, 11](#) and [12](#) for projection methodologies based on provider types. Contractors must net out the dollar amount of charges underbilled.

Amounts of the following overpayments are to be included in each provider's estimate of overpayments for the sample:

- Initially paid claims which are denied on re-adjudication, and for which the provisions of [§1879](#) apply and the provider is liable for the overpayment because: (1) the provider knew or could reasonably have been expected to know that items or services were excluded from coverage, and (2) the provider was not without fault for the overpayment under [§1870](#).*
- Initially paid claims which are denied on re-adjudication, and for which the provisions of [§1879](#) do not apply, but the provider is liable because it is determined to be not without fault for the overpayment under [§1870](#).*
- Initially denied claims which are found to be payable on readjudication (in whole or in part). Such claims should be included to reduce the amount of the overpayment sample.*

For appeal purposes, overpayment estimations will be separately identified for denials in which [§1879](#) is applied, and denials in which [§1879](#) does not apply. Where both types of denials occur in the sample, contractors calculate and document separate under/overpayments for the two types of denials. For recovery purposes, however, both denial results are combined.

6.5 – Notification of Provider(s) and Beneficiaries of the Postpayment Review Results {tc "6.9 – Final Notification of the CMR Results/Demand Letter" | 2} (Rev. 17, 12-12-01)

This section applies to all three types of postpayment reviews (error validation reviews, statistical sampling reviews, and consent settlement reviews).

A -- Provider Notification

Contractor MR staff must prepare a letter to notify each provider of the results of the postpayment review. These letters may (but are not required to) contain a demand for repayment of any overpayments they may have made. Some contractors may wish to have another department issue the actual demand letter. Contractors must notify the provider(s) that the postpayment review has been completed even in those instances where no corrective actions or overpayments are involved.

Contractors must send the Notification of Postpayment Review Results to each provider within 60 days of the exit conference (for provider-site reviews) or receipt of medical records (for contractor site reviews). If the contractors need more than 60 days, they are to contact their RO for an extension. Each letter must include:

- *Identification of the provider(s)--name, address, and provider number;*
- *The reason for conducting the review;*
- *A narrative description of the overpayment situation: state the specific issues involved which created the overpayment and any pertinent issues as well as any recommended corrective actions the provider should consider taking;*
- *The findings for each claim in the sample, including a specific explanation of why any services were determined to be non-covered, or incorrectly coded; A list of all individual claims including the actual amounts determined to be noncovered, the specific reason for noncoverage, the amounts denied, the amounts which will not be recovered from the provider, under/overpayment amounts and the [§§1879](#) and [1870](#) determinations made for each specific claim;*
- *For statistical sampling reviews, any information required by PIM [Exhibit 7](#);*
- *Total underpayment amounts;*
- *Total overpayment amounts for which the provider is responsible;*
- *Total overpayment amounts for which the provider is not responsible because the provider was found to be without fault;*

- *Intermediaries must include an explanation that subsequent adjustments may be made at cost settlement to reflect final settled costs;*
- *An explanation of the provider's right to submit a rebuttal statement prior to recoupment of any overpayment (see PIM Chapter 3, Section 6.6);*
- *An explanation of the procedures for recovery of overpayments including Medicare's right to recover overpayments and charge interest on debts not repaid within 30 days, and the provider's right to request an extended repayment schedule;*
- *The provider appeal rights; and*
- *A discussion of any additional corrective actions or follow-up activity the contractor is planning (i.e., prepayment review, re-review in 6 months, etc.).*

Contractors may send the final notification letter by certified mail and return receipt requested.

Sample letters are in PIM [Exhibit 7.6](#) with attachment [Exhibit 7.6.1](#) and the Part B sample letter is [Exhibit 7.7](#) with attachment [Exhibit 7.7.1](#). Contractors may adapt the language used under each heading to the particular situation they are addressing.

B -- Beneficiary Notification

Contractors must also notify each beneficiary when re-adjudication of the claim results in a change to the initial determination. This can be done via an MSN of individual letter. In the case where a sample of claims is extrapolated to the universe, only those beneficiaries in the sample need be notified.

6.6 – Provider(s) Rebuttal(s) of Findings{tc "6.2.4 – Provider Rebuttal of Findings" \l 3} (Rev. 17, 12-12-01)

This section applies to all three types of postpayment reviews (error validation reviews, statistical sampling reviews, and consent settlement reviews).

A -- Provider(s) Timeframes for Submitting Rebuttal Statements

Within 15 working days of notification of the results, each provider may submit a rebuttal statement in accordance with [42 CFR 405.374](#). The rebuttal statement and any accompanying evidence must be submitted within 15 working days from the date of the notification letter described in section 6.5 unless MR or Audit/Reimbursement (A/R) staff find cause otherwise to extend or shorten the time afforded for submission of the statement. The provider's rebuttal statement should address why the recovery should not be put into effect on the date specified in the notification letter.

B -- Contractor Review of Rebuttal Statement(s)

MR and A/R staff should consider all of the evidence timely submitted to reach a determination regarding whether the determinations were incorrect and whether recoupment should be

delayed. However, recovery of any overpayment will not be delayed beyond the date indicated in the notification letter in order to review and respond to the rebuttal statement even if the principal of the debt is modified after reviewing the rebuttal statement. (See [42 CFR 405.375\(a\)](#).)

EVIDENCE IS CLEAR THAT DETERMINATION IS INCORRECT

In order to avoid unnecessary appeals, if it is clear from the evidence submitted that the revised determination was in whole, or in part, incorrect, the contractor may consider such evidence. If such evidence warrants changes to any claims determinations made during the postpayment review, they work with Audit/Reimbursement staff to recalculate the amount of the overpayment, and issue a modified revised determination. Since the provider(s) has previously had an opportunity to submit a rebuttal statement, the contractor is not required to offer a provider an opportunity to submit a rebuttal statement in response to the modified revised determination. The provider may challenge the claims determinations and sampling methodology in the administrative appeals process.

EVIDENCE IS INSUFFICIENT THAT DETERMINATION IS INCORRECT

If it is unclear from the evidence that the determination was incorrect, the contractors must notify the provider(s) and remind them of their appeal rights and tell them that they found the evidence insufficient to modify the determination..

C -- Cost Report Issues

Because of the cost report relationship to the overpayment, it is important to note that the projected overpayment recovered from a provider as a result of a postpayment review using statistical sampling is based on the interim payment rate in effect at the time of the review.

6.7 - Recovery of Overpayments (Rev. 17, 12-12-01)

This section applies to all three types of postpayment reviews (error validation reviews, statistical sampling reviews, and consent settlement reviews).

Contractor MR staff shall refer all overpayments to overpayment staff for recoupment.

After MR staff issues revised determinations that notify the provider(s) of the postpay review results, their intention to recoup or offset payment and the provider's right to submit a rebuttal statement, the contractor's Audit/Reimbursement (A/R) or overpayment staff may begin recovery of the estimated total overpayment on the 15th day from the date of the notification letter to the provider (e.g., the day the rebuttal period ends).

Contractor overpayment staff or A/R staff shall recover all overpayments for which the provider is liable and/or at fault after making adjustments for any under-payments in accordance with [42 CFR 405.373](#);

6.8 – Evaluation of the Effectiveness of Postpayment Review and Next Steps (Rev. 17, 12-12-01)

This section applies to all three types of postpayment reviews (error validation reviews, statistical sampling reviews, and consent settlement reviews).

Contractors must determine if any other corrective actions are necessary such as:

- *In cases where the MR unit uncovers potential fraud in the course of its postpayment review activities, the MR unit shall refer these cases to the fraud unit. If it is believed that the overpayment has been caused by fraud, do not request a refund until the fraud issue is resolved (see PIM [Chapter 3, Section 8](#)).*
- *Initiate provider specific edit to focus prepayment review on the problem provider or group of providers (see PIM Chapter 3, Section 5.1) if appropriate;*
- *Work with the RO to suspend payment to the provider or group of providers (see PIM [Chapter 3, Section 9](#));*
- *Refer provider certification issues to the State survey agency through the RO staff.*
- *Refer quality issues involving inpatient hospital services, if any, to the PRO;*
- *Coordinate with the PRO and carrier/intermediary on interrelated billing problems;*

Contractors perform a follow-up analysis of the provider(s) periodically for as long as necessary to determine if further corrective actions are required. In some cases, it may be feasible and timely to perform the follow-up analysis of the provider after the 3 month time period.

Contractors must continue monitoring the provider or group of providers until there is a referral to the fraud unit, there is evidence that the utilization problem is corrected, or data analysis indicates resources would be better utilized elsewhere. (See [Progressive Corrective Action PM - transmittal AB-00-72](#))

6.9 - Postpayment Files (Rev. 17, 12-12-01)

Contractors must establish an audit trail that identifies:

- *Claims and beneficiaries selected;*
- *The period of review;*
- *The reason for the review (aberrancy validation, high provider error rate, wide-spread service-specific problem.); and*
- *Findings to show why the original claim determination was changed. The documentation must be clear and concise, and include the basis for revision.*

Contractors must complete a Summary Report for each postpayment review case. Include in the report:

- *The reason(s) the provider or group of providers was selected for review;*
- *A chronological record of all review events and actions;*
- *The information used to perform the review (e.g., relevant LMRP);*

- *A record of all decisions made and all actions taken to deal with the provider's MR problem, including who made the decisions and the reasons for taking the actions;*
- *Documentation of statistical methods used if overpayment is projected;*
- *Whenever possible, postpayment savings in terms of actual overpayment, settlement based, or statistically extrapolated;*
- *A record of all contacts with providers or beneficiaries; and*
- *Documentation of §§1879, 1870, or 1842(1) determinations. (See PIM [Exhibit 14.](#))*

Retain the Summary Report and all postpay files for 36 months following the conclusion of a postpay case unless the RO requires a longer period or unless the case is referred to the BI unit (and in this case, retain the files for the longer of 36 months or the completion of the investigation). A sample summary report is found in [Exhibit 13](#). Contractors have the option of using an alternate format for the postpay summary report with RO approval.

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PIM Exhibits
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Medicare Program Integrity Manual

Exhibits

Table of Contents
(Rev. 17, 12-12-01)

[14 - Contractor Denials 1862\(a\)\(1\) of the Act](#)

[14.1 - Section 1879 of the Act Determination - Limitation of Liability](#)

[14.2 - Section 1870 of the Act Determination - Waiver of Recovery of an Overpayment](#)

[14.3 - Section 1842\(1\) of the Act Determination - Refunds to Beneficiary](#)

14.4 - Effect of Sections 1879 and 1870 of the Social Security Act During Postpayment Reviews

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Exhibit 14.4 - Effect of Sections 1879 and 1870 of the Social Security Act During Postpayment Reviews (Rev. 17, 12-12-01)

The Medicare law contains two provisions that affect the determination and the recovery of overpayments. One is §1879 of the Act, which deals with limitation on liability for services determined to be noncovered because they are, for example, custodial or are not reasonable and necessary under Medicare law, or, for home health services, the patient is not confined to home or the skilled nursing services are not intermittent. If the denial involves items or services to which the provisions of §1879 (limitation on liability) apply, MR makes a determination in accordance with instructions in MIM §3431, MCM §7300 and [HCFA Ruling 95-1](#).

The other law affecting the determination and the recovery of overpayments is §1870 of the Act, which provides a framework within which liability for overpayments is determined and recovery of overpayments is pursued. If the denial of a claim involves items or services to which the provisions of §1879 (limitation on liability) do not apply, or if an overpayment results from a §1879 determination that either the beneficiary or the provider is liable, contractors make a determination as to whether the provider was without fault for the overpayment under the provisions of §1870 in accordance with MIM §3431 and MCM §7300.