CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-08 Medicare Program Integrity	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 10228	**Date: July 27, 2020**
	Change Request 11884

SUBJECT: Updates to Chapters 1, 2, 3, 4, 5, 6, 7, 8, 10, 11, and Exhibits of Publication (Pub.) 100-08

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update all references of Program Safeguard Contractor (PSC) and Zone Program Integrity Contractor (ZPIC) to Unified Program Integrity Contractor (UPIC) within Chapters 1, 2, 3, 4, 5, 6, 7, 8, 10, 11, and Exhibits in Pub. 100-08.

EFFECTIVE DATE: August 27, 2020
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: August 27, 2020

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row*.

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III. FUNDING:

For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately

notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-08	Transmittal: 10228	Date: July 27, 2020	Change Request: 11884

SUBJECT: Updates to Chapters 1, 2, 3, 4, 5, 6, 7, 8, 10, 11, and Exhibits of Publication (Pub.) 100-08

EFFECTIVE DATE: August 27, 2020
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: August 27, 2020

I. GENERAL INFORMATION

A. Background: The CMS is making revisions to Chapters 1, 2, 3, 4, 5, 6, 7, 8, 10, 11, and Exhibits in Pub. 100-08 to update all references of Program Safeguard Contractor (PSC) and Zone Program Integrity Contractor (ZPIC) to Unified Program Integrity Contractor (UPIC).

B. Policy: This CR does not involve any legislative or regulatory policies.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
11884.1	Contractors shall be aware that all references to Program Safeguard Contractor (PSC) and Zone Program Integrity Contractor (ZPIC) within Chapters 1, 2, 3, 4, 5, 6, 7, 8, 10, 11, and Exhibits in Pub. 100-08 shall now be referred to as Unified Program Integrity Contractor (UPIC).	X	X	X	X					CERT, UPICs

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Jesse Havens, 410-786-6566 or jesse.havens@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

Medicare Program Integrity Manual

Chapter 1 – Medicare Improper Payments: Measuring, Correcting, and Preventing Overpayments and Underpayments

Table of Contents

(Rev. 10228; Issued: 07-27-20)

1.1 - Overview of Program Integrity and Provider Compliance

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

The term "Review Contractor" throughout the Program Integrity Manual refers to:

- Medicare Administrative Contractors (MACs)
- Comprehensive Error Rate Testing (CERT) contractors
- Recovery Auditors
- *Unified Program Integrity Contractors (UPICs)*
- Supplemental Medical Review Contractor (SMRC)

Review Contractors shall follow all sections of the PIM unless otherwise indicated as required by their applicable Statements of Work (SOW).

1.3.3 - Applicable Program Integrity Manual Sections

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

- The MACs, CERT, Recovery Auditors, *UPICs*, and SMRC shall follow all sections of the PIM unless otherwise indicated

- The MACs, CERT, Recovery Auditors, *UPICs* and SMRC shall follow the PIM to the extent outlined in their SOWs.

1.3.6 - Quality of Care Issues and Potential Fraud Issues

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

- Potential quality of care issues are not the responsibility of the MAC, CERT or Recovery Auditor, *UPIC*, and SMRC but they are the responsibility of the QIO, State licensing/survey and certification agency, or other appropriate entity in the service area. MACs, CERT, Recovery Auditor, *UPICs* and SMRC shall refer quality of care issues to the QIO, State licensing/survey and certification agency, or other appropriate entity in the service area. See chapter 3, section 3.1, for a discussion of how contractors should handle situations where providers are non-compliant with Medicare conditions of participation.

- Contractors shall analyze provider compliance with Medicare coverage and coding rules and take appropriate corrective action when providers are found to be non-compliant. For repeated infractions, or infractions showing potential fraud or pattern of abuse, more severe administrative action shall be initiated. At any time, evidence of fraud shall result in referral to the *UPICs* for development. See chapter 4, section 4.18.3 for a discussion on benefit integrity interaction with QIOs.

1.3.7 - The MAC and SMRC Medical Review Program

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

The MR program is designed to prevent improper payments in the Medicare FFS program. Whenever possible, MACs are encouraged to automate this process; however, it may require the evaluation of medical records and related documents to determine whether Medicare claims were billed in compliance with coverage, coding, payment, and billing policies.

The statutory authority for the MR program includes the following sections of the Social

Security Act (the Act):

- Section 1833(e) which states, in part "...no payment shall be made to any provider... unless there has been furnished such information as may be necessary in order to determine the amounts due such provider ...;"

- Section 1842(a)(2)(B) which requires ACs and MACs to "assist in the application of safeguards against unnecessary utilization of services furnished by providers…;"

- Section 1862(a)(1) which states no Medicare payment shall be made for expenses incurred for items or services that "are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member;"

- The remainder of Section 1862(a) which describes all statutory exclusions from coverage;

- Section 1893(b)(1) establishes the Medicare Integrity Program which allows contractors to review activities of providers of services or other individuals and entities furnishing items and services for which payment may be made under this title (including skilled nursing facilities and home health agencies), including medical and utilization review and fraud review (employing similar standards, processes, and technologies used by private health plans, including equipment and software technologies which surpass the capability of the equipment and technologies. . .”

- Sections 1812, 1861, and 1832 which describe the Medicare benefit categories; and

- Sections 1874, 1816, and 1842 which provide further authority.

The regulatory authority for the MR program rests in:

- 42 CFR 421.100 for intermediaries.
- 42 CFR 421.200 for carriers.
- 42 CFR 421.400 for MACs.

The *UPICs* shall refer to chapter 4 for MR for BI purposes.

1.3.8 - Goal of MAC and SMRC MR Program

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

The goal of the MAC and SMRC MR program is to reduce payment error by preventing the initial payment of claims that do not comply with Medicare’s with coverage, coding, payment, and billing policies. To achieve the goal of the MR program,

MACs:

- Identify provider noncompliance with coverage, coding, billing, and payment policies through analysis of data. (e.g., profiling of providers, services, or beneficiary utilization) and evaluation of other information (e.g., complaints, enrollment and/or cost report data). (Chapter 2 describes these activities in further detail.);

- Take action to prevent and/or address the identified improper payment; (chapter 3, describes these actions in further detail.); and

- Place emphasis on reducing the paid claims error rate by notifying the individual billing entities (i.e., providers, suppliers, or other approved clinician) of review findings identified by the ACs or by the MACs and making appropriate referrals to provider outreach and education (POE), and *UPICs*.

SMRC:

- Identify provider noncompliance with coverage, coding, billing, and payment policies through the research and analysis of data related to assigned task. (e.g., profiling of providers, services, or beneficiary utilization)

- As directed by CMS, perform medical review

- As directed by CMS, perform extrapolation

- Notify the individual billing entities (i.e., providers, suppliers, or other approved clinician) of review findings identified and make appropriate recommendations for POE and *UPIC* referrals

1.3.10 - Coordination Among Contractors

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

A. Coordination among MACs *and UPICs*

The MAC MR staff shall coordinate and communicate with their associated *UPIC* to ensure coordination of efforts and to prevent inappropriate duplication of review activities. At any time, suspicion of fraud should result in referral to the *UPIC* for development.

B. Coordination among MACs and the Recovery Auditors

See Pub. 100-06, Financial Management Manual, chapter 4, section 100.1-100.15, for a description of the coordination efforts between MACs and Recovery Auditors. In addition, the MACs shall coordinate and communicate with the Recovery Auditors to get the specifics on Recovery Auditor identified vulnerabilities for use in the MAC's data analysis and possible corrective actions.

C. SMRC

The SMRC shall make all recommendations for referrals through their CMS Contract Officer Representative (COR).

1.7 - Benefit Integrity

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

A. Contractors to Which This Section Applies

This section applies to *UPICs* only.

B. General

In addition to reducing improper payments, CMS strives to protect the program from potential fraud. CMS contracts with *Unified Program Integrity Contractors (UPICs)* to identify and stop potential fraud.

The primary task of *UPICs* is to identify cases of suspected fraud, develop them thoroughly and in a timely manner, and take immediate action to ensure that Medicare Trust Fund monies are not inappropriately paid out and that any mistaken payments are identified. *UPICs* shall refer cases of potential fraud to the Department of Health and Human Services (HHS) Office of Inspector General (OIG) Office of Investigations (OI).

1.8 - Medical Review for Benefit Integrity (MR for BI)

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

A. Contractors to Which This Section Applies

This section applies to *UPICs*.

B. General

The goal of the MR for BI program is to address situations of potential fraud, waste, and abuse (e.g., looking for possible falsification).

Information on maintaining the confidentiality of MR documents can be found in this chapter, section 1.6.

Medicare Program Integrity Manual

Chapter 2 – Data Analysis

Table of Contents
(Rev. 10228; Issued: 07-27-20)

Transmittals for Chapter 2

2.1 - Identifying Potential Errors – Introduction

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

A. Contractors To Which This Section Applies

This section applies to MACs, *UPICs*, Recovery Auditors, and Supplemental Medical Review Contractor (SMRC).

B. General

This chapter specifies resources and procedures to the MACs, *UPICs*, Recovery Auditors, and the SMRC. The contractors shall use these instructions to identify and verify potential errors to produce the greatest protection to the Medicare program. Contractors should objectively use analytical methodologies to evaluate potential errors and not take administrative action unless they have verified the error and determined that the error is a high enough priority to justify the action. They should also archive the error including supporting rationale for selection. (See Reliable Information in Pub. 100-08, Exhibits, Exhibit 4.)

C. Review of Data

Data analysis is an essential first step in determining whether patterns of claims submissions and payments indicate potential problems. Such data analysis should include identification of statistical outliers in billing patterns within a well-defined group, or more sophisticated detection of patterns within claims or groups of claims that might suggest improper billing or payment.

Data analysis shall be undertaken as part of general surveillance and review of submitted claims, or shall be conducted in response to information about specific problems stemming from complaints, provider or beneficiary input, fraud alerts, reports from CMS, other MACs, or independent government and nongovernmental agencies.

2.2 - Data Analysis

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

A. Contractors To Which This Section Applies

This section applies to MACs, *UPICs*, SMRC. This section does not apply to the Recovery Auditors. Recovery Auditors should follow the data analysis instructions listed in their Statement of Work.

B. General

Data analysis is a tool for identifying actual or potential claim payment errors. Data analysis applies well-established statistical methods to claim information and other related data to identify potential errors and potential fraud by claim characteristics (e.g., diagnoses, procedures, providers, or beneficiaries) individually or at an aggregate level. Data analysis is an integrated, on-going component of MR and benefit integrity (BI) activity.

The MACs and *UPICs* ability to make use of available data and apply innovative analytical methodologies is critical to the success of the MR and BI programs. They should use research and experience in the field to develop new approaches and techniques of data analysis. The MACs and *UPICs* should have ongoing communication with other government organizations

(e.g., QIOs and the State Medicaid agencies) concerning new methods and techniques.

Analysis of data should:

- Identify those areas of potential errors (e.g., services which may be non-covered or not correctly coded) that pose the greatest risk;

- Establish baseline data to enable the recognition of unusual trends, changes in utilization over time, or schemes to inappropriately maximize reimbursement;

- Identify where there is a need for an LCD;

- Identify where there is a need for targeted education efforts;

- Suggest claim review strategies that efficiently prevent or address potential errors (e.g., prepayment edit specifications or parameters);

- Produce innovative views of utilization or billing patterns that illuminate potential errors;

- Identify high volume or high cost services that are being widely overutilized. This is important because these services do not appear as an outlier and may be overlooked when, in fact, they pose the greatest financial risk;

- Identify program areas and specific providers for possible fraud investigations; and

- Determine if major findings identified by Recovery Auditors, CERT, and CMS represent significant problem areas in the MAC's jurisdiction.

This data analysis program shall involve an analysis of national data furnished by CMS as well as review of internal billing utilization and payment data to identify potential errors.

The goals of the data analysis program are to identify provider billing practices and services that pose the greatest financial risk to the Medicare program.

The MACs and *UPICs* shall document the processes used to implement their data analysis program and provide the documentation upon request.

In order to implement a data analysis program, the MACs and *UPICs* shall:

- Collect data from sources such as:

o Historical data, e.g., review experience, denial data, provider billing problems, provider cost report data, provider statistical and reimbursement (PS&R) data, billing data, payment data, utilization data, data from other Federal sources (e.g., QIO, other MACs, Medicaid); and

o Common Working File (CWF)

- Referrals from internal or external sources (e.g., 1-800 Medicare Call Center, provider audit, beneficiary, State Senior Medicare Patrol, or other complaints).

The shared system maintainer shall allow MACs the ability to select claims using the NPI or the

legacy number (OSCAR or UPIN) as a criterion for medical review.

C. Resources Needed for Data Analysis

The MACs and *UPICs* shall have available sufficient hardware, software, and personnel with analytical skills to meet requirements for identifying problems efficiently, and effectively developing and implementing corrective actions. If MACs are unable to employ staff with the qualifications necessary for effective data analysis, evaluation and reporting, they shall use other entities (e.g., universities, consultants, other contractors) who can provide the technical expertise needed. The following are minimum resource requirements for conducting data analysis, evaluation, and reporting.

1. Data Processing Hardware

Adequate equipment for data analysis includes facilities to process data (e.g., mainframes and personal computers) and to store data (e.g., tape drive, disk drives, etc.). Upgrading current resources (e.g., mainframe computers, shared systems, etc.) or the purchase of new capabilities (e.g., microcomputer workstations or subcontracts for computer services) may provide additional processing capabilities. In addition, MACs and *UPICs* shall have secure telecommunication capabilities to interact with the CMS Data Center.

2. Data Processing Software

The CMS provides MACs and *UPICs* with software to allow communication with the CMS Data Center. At their discretion, MACs and *UPICs* that wish to develop or acquire additional software that allows for analysis of internal data or other data obtained from the CMS Data Center may do so. The MACs and *UPICs* should have internal software to support the analyses of data to meet program goals.

3. Personnel

The MACs and *UPICs* shall have staff with appropriate training, expertise and skills to support the application of software and conduct systematic analyses and clinical evaluation of claims data. CMS strongly encourages MACs and *UPICs* to have staff with clinical expertise (e.g., registered nurses) and a mix of skills in programming, statistics, and data mining analysis (e.g., trending and profiling of providers/codes).

The MACs and *UPICs* shall also employ a staff that has training in developing analytical and sampling strategies for overpayment projections.

D. Frequency of Analysis

The MACs shall have a minimum of 18 months of data but are encouraged to have 36 months. The MACs shall, at a minimum, compare the current 6-month period to the previous 6-month period to detect changes in providers' current billing patterns and to identify trends in new services. Summary data or statistically representative samples can be used when dealing with very large volumes of data.

E. Determine Indicators to Identify Norms and Deviations

The MACs and *UPICs* shall develop indicators that will be used to identify norms, abnormalities, and individual variables that describe statistically significant time-series trends

and the most significant abnormalities or trends. Examples of indicators or variables are:

- Standard deviations from the mean;
- Percent above the mean or median;
- Percent change in billing activity, payment charges, and number of visits/services from one period to another.
- Rate of change over specified periods in time.

F. Document Data Strategy

While the CMS is deliberately not prescriptive in terms of the technical details of how to reach data analysis goals, MACs and *UPICs* are expected to develop the most sophisticated and effective methods and procedures to meet these goals and will be held accountable for accurate, effective reports, procedures, and quality outcomes.

2.3 - Sources of Data for *UPICs*

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

A. Contractors To Which This Section Applies

This section applies to *UPICs*.

B. General

The *UPICs* approach for combining claims data (MAC data, Recovery Auditor data from the Recovery Auditor data warehouse) and other data to create a platform for conducting complex data analysis shall be documented in their Information Technology Systems Plan. By combining data from various sources, the *UPIC* will present an entire picture of a beneficiary's claim history regardless of where the claim was processed. The primary source of this data will be the CMS shared systems data, National Claims History (NCH), and Integrated Data Repository (IDR). The *UPIC* shall be responsible for obtaining data for all beneficiaries for whom the MAC(s) paid the claims.

At a minimum, *UPICs* are required to store the most recent 36 months' worth of data (including Part A, Part B, DME, home health & hospice) for the jurisdiction or zone defined in their task order.

If the jurisdiction of the MAC(s) is not defined geographically, the *UPIC* shall obtain a complete beneficiary claims history for each unique beneficiary for whom the MAC(s) paid a claim.

EXAMPLE 1: The MAC(s) jurisdiction covers Maryland but includes a hospital chain with facilities in Montana. The *UPIC* would request claims history from shared systems, NCH, or IDR

for all claims paid by the MAC(s).

EXAMPLE 2: The MAC(s) jurisdiction covers Maryland, a beneficiary lives in Pennsylvania, and the beneficiary saw a doctor in Maryland. The *UPIC* would request from shared systems, NCH, or IDR for all claims paid by the MAC(s).

The *UPICs* will not be able to tap data from the Common Working File (CWF).

The *UPICs* should, at their discretion, if agreement and cooperation of the MAC(s) are obtained, use data directly from the claims processing system of the MAC(s), and then supplement the other data using NCH. In developing this plan, the *UPICs* shall address the above requirements and, at a minimum, establish read-only access to the MAC's shared claims processing system(s) and access to the Part A, B, and D data available through the NCH for the jurisdictional area defined in the Task Order. The *UPIC* shall obtain denial data through the MACs and document the process for obtaining this data from the MAC(s) in the Joint Operating Agreement. At a minimum, the denial data shall include data for edits that were requested and/or recommended by the *UPIC*.

The *UPIC* shall have the ability to receive, load, and manipulate CMS data. The data shall also be maintained in accordance with CMS and Federal privacy laws and regulations as described in the CMS Data Use Agreement. For planning purposes, the *UPICs* should assume that there are 30 claims per Medicare beneficiary identifier (Mbi) per year, on average. A claim record is about 1000 bytes. To calculate the storage space necessary, use the following formula:

(#Mbis) X (30 claims) X (#years) X (1000) = #bytes

The CMS contract officer's representative (COR) and *UPIC* will need to complete:

- A data use agreement to give permission to receive privacy protected data;
- A Data request form to specify all data required by the *UPIC*;
- A HDC application for HDC access and/or CMS systems' access to get access to the data center and/or to specify which CMS systems the *UPIC* will access;
- A DESY system application form. (This is provided to the *UPIC* post- award).

2.4 - Sources of Data for MACs and *UPICs*

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

A. Contractors To Which This Section Applies

This section applies to MACs and *UPICs*. The sources of data for CERT and Recovery Auditors are specified in their SOWs.

B. General

The data sources that MACs and *UPICs* use will depend upon the issue(s) being addressed and the availability of existing data. CMS maintains numerous systems housing Medicare, Parts A, B, and D claims, Beneficiary Entitlement, Enrollment and Utilization data, Provider reference information. The IDR is the enterprise resource designed to house and unify the data from disparate systems to enable cross-cutting reporting and analysis. The IDR has been created with

an aim toward reducing data redundancy, providing flexibility to satisfy changing business needs and serve as the relational data warehouse for core CMS data. The IDR provides the system platform and database structures which enable one store of data to meet the various needs of our MAC and *UPIC* community. The repository is leveraged by multiple reporting, analytical and operational production applications.

Systematic data analysis requires MACs and *UPICs* to have in place the hardware and software capability to profile providers in aggregate, by provider type, by common specialties among providers, or individually. Some of the provider information that should be used includes:

- Types of providers;
- Volume of business;
- Volume (or percentage) of Medicare/Medicaid patients;
- Prevalent types of services;
- Location;
- Relationships to other organizations;
- Types of ownership;
- Previous investigations by the *UPIC*;
- Size and composition of staff;
- Administrative costs;
- Claims history; and
- Other information needed to explain or clarify the issue(s) in question.

Where possible, the selection of providers should show a representative grouping, in order to accurately reflect the extent of program losses.

C. Primary Source of Data

Claims data is the primary source of information used to identify and target fraudulent, wasteful or abusive activities. Sources of claims data are:

- IDR--MACs and *UPICs* should utilize the reports accessible in the system platform and database structures. Reports include the following:

o Claims Summary Information report (CSI) which used to be called Health Care Information System (HCIS),

o Part B Analytics System Report (PBASR), which show comparative utilization ratios by code, MAC, and specialty,

- Short Term Alternatives for Therapy Services (STATS) which shows Outpatient therapy professional and provider claims data,

- IDR Analysis Reports which include analysis reports and IDR volume and statistics, and

- Focused Medical Review (FMR) which shows Part B claims utilization and enrollment data.

The MACs and *UPICs* shall also use national data where available. National data for services billed by skilled nursing facilities (SNFs) and home health agencies (HHAs) is available at the CMS Data Center. When made available, contractors can access through CMS One Program Integrity (see below One PI) or the CMS Enterprise Portal.

- CMS One Program Integrity (One PI) – Serves as a system application, tool and databases providing access to the CMS IDR which houses, at a minimum, the most current Medicare Parts A and B billing and payment data;

- Contractor Local Claims Data – Local data should be compiled in a way to identify which providers or type of service in the contractor's area may be driving any unusual utilization patterns;

- CMS Fraud Prevention System(FPS)--When access is available, MACs should consider periodically reviewing the information and data trends resulting from national predictive models contained in the FPS;

- CMS PBASR--The Report stores data sets that contain annual timeframes, and Healthcare Common Procedure Coding System HCPCs/CPT codes that correspond to provider/supplier disciplines. Each data set displays the allowed services, allowed charges, and payment amounts by HCPCs/CPT codes and prominent modifiers. The PBAR is only accessible through the Enterprise Portal; and

- CMS Claims Summary Information (CSI)——Files contain Medicare Part A (i.e., Inpatient, Skilled Nursing Facility, Home Health Agency (Part A & B) and Hospice) and Medicare Part B (i.e., Outpatient) information based on the type and State of the institutional provider. The data set names correspond with the provider type. Brief descriptions of the provider types and the selected reporting elements (e.g., units of service, billed charges, provider ZIP code, etc.) are provided. Access is through the One PI portal.

D. Secondary Sources of Data

The MACs and *UPICs* should consider other sources of data in determining areas for further analysis. These include:

- OIG and Government Accountability Office (GAO) reports;

- Fraud Alerts;

- Beneficiary, physician and provider complaints;

- Appeals data from QICs, including appeals overturn rate for a particular type of claim;

- Referrals from the QIO, other contractors, CMS components, Medicaid fraud control units,

Office of the U.S. Attorney, or other federal programs;

- Suggestions provided directly or implicit in various reports and other materials produced in the course of evaluation and audit activities, (e.g., contractor evaluations, State assessment, CMS-directed studies, contractor or State audits of providers);

- Referrals from medical licensing boards;

- Referrals from the CAC;

- Peer Review Reports such as the First-look Analysis Tool for Hospital Outlier Monitoring (FATHOM) and Program to Evaluate Payment Patterns Electronic Report (PEPPER), and Comparative Billing Reports;

- Information on new technologies and new or clarified benefits;

- Provider cost reports;

- Provider Statistical and Reimbursement (PS&R) System data;

- Enrollment data;

- Overpayment data;

- Pricing, data analysis, and coding (PDAC) data;

- Referrals from other internal and/or external sources (e.g., MAC audit staff, audit staff or, MAC quality assurance (QA) staff);

- Medicare Learning Network – which includes MedLearn Matters articles and Quarterly Provider Compliance Newsletters;

- IBM Cognos support for the Part D and Drug Data Processing System (DDPS) using the Teradata data repository;

- CMS prepared data, such as a listing of distinct providers or suppliers and/or bills that require medical review.

While the MAC, Recovery Auditor, and *UPIC* should investigate reports from the GAO, congressional committees, Office of Inspector General Office of Audit Services (OIG OAS), OIG OI, newspaper and magazine articles, as well as local and national television and radio programs, highlighting areas of possible abuse, these types of leads should not
in source for leads on fraud, waste or abuse cases.

Medicare Program Integrity Manual

Chapter 3 – Verifying Potential Errors and Taking Corrective Actions

Table of Contents

(Rev. 10228; Issued; 07-27-20)

3.1 - Introduction

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

All references to Medicare Administrative Contractors (MACs) include Affiliated Contractors (ACs). Affiliated Contractors are FI's and Carriers.

A. Goals

This section applies to Medicare Administrative Contractors (MACs), Comprehensive Error Rate Testing (CERT), and Recovery Auditors, as indicated.

The Medicare Administrative Contractors (MACs) shall analyze claims to determine provider compliance with Medicare coverage, coding, and billing rules and take appropriate corrective action when providers are found to be non-compliant. The goal of MAC administrative actions is to correct the behavior in need of change and prevent future inappropriate billing. The priority for MACs is to minimize potential future losses to the Medicare Trust Funds through targeted claims review while using resources efficiently and treating providers and beneficiaries fairly.

For repeated infractions, MACs have the discretion to initiate progressively more severe administrative action, commensurate with the seriousness of the identified problem. (Refer to PIM chapter 3, §3.7.1). MACs shall deal with serious problems using the most substantial administrative actions available, such as 100 percent prepayment review of claims. Minor or isolated inappropriate billing shall be remediated through provider notification or feedback with reevaluation after notification. When medical review (MR) notification and feedback letters are issued, the MAC MR staff shall ensure that Provider Outreach and Education (POE) staff has access to copies of the letters in case a provider requests further education or POE determines that future education is needed. While program savings are realized through denials of payment for inappropriate provider billing, the optimal result occurs when compliance is achieved and providers no longer incorrectly code or bill for non-covered services.

The Medicare Fee For Service Recovery Audit program is a legislatively mandated program (Tax Relief and Health Care Act of 2006) that utilizes Recovery Auditors to identify improper payments paid by Medicare to fee-for-service providers. The Recovery Auditors identify the improper payments, and the MACs adjust the claims, recoup identified overpayments and return underpayments.

MAC, CERT and Recovery Auditor staff shall not expend Medicare Integrity Program (MIP)/ MR resources analyzing provider compliance with Medicare rules that do not affect Medicare payment. Examples of such rules include violations of conditions of participation (COPs), or coverage or coding errors that do not change the Medicare payment amount. The COPs define specific quality standards that providers shall meet to participate in the Medicare program. A provider's compliance with the COPs is determined by the CMS Regional Office (RO) based on the State survey agency recommendation. If during a review, any contractor believes that a provider does not comply with conditions of participation, the reviewer shall not deny payment solely for this reason. Instead, the contractor shall notify the RO and the applicable State survey agency.

When a potential underpayment or overpayment is identified, certain steps are normally followed to determine if a payment error exists. These steps are referred to as the claims development process. The reviewer generally does the following:

- Investigates the claims and associated documentation;

- Performs appropriate research regarding liability, benefit categories, statutory requirements, etc.;
- Determines if a payment error exists and the nature of the error;
- Notifies the beneficiary and provider/supplier; and
- Starts the payment reconciliation process.

B. New Provider/New Benefit Monitoring

This section applies to the MACs.

The MACs shall analyze data to identify patterns of billing aberrancies of providers new to the Medicare program. The MACs have the option of performing prepayment or postpayment review of claims submitted by new providers as needed. The CMS encourages the MACs to perform these reviews on a prepayment basis to have the greatest chance of identifying and reducing the error rate of new providers. When MACs review the claims of a new provider, the MACs shall perform a limited review of generally 20-40 claims in order to evaluate accurate billing.

The MACs shall also monitor for provider use of new statutory benefits and to ensure correct coverage, coding, and billing from the beginning. New benefit edits shall continue until the MAC is satisfied that the new benefits are being used and billed appropriately or until the MAC determines that resources would best be spent on other types of review.

3.2 - Overview of Prepayment and Postpayment Reviews

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

This section applies to MACs, CERT, RACs, SMRCs, and *Unified Program Integrity Contractors (UPICs)*, as indicated.

A. Prepayment and Postpayment Review

Prepayment review occurs when a reviewer makes a claim determination before claim payment has been made. Prepayment review always results in an “initial determination”

Postpayment review occurs when a reviewer makes a claim determination after the claim has been paid. Postpayment review results in either no change to the initial determination or a “revised determination” indicating that an overpayment or underpayment has occurred.

B. Prepayment Edit Capabilities

Prepayment edits shall be able to key on a beneficiary's Medicare beneficiary identifier (Mbi), National Provider Identifier (NPI) and specialty code, service dates, and diagnosis or procedure code(s) (i.e., Healthcare Common Procedure Coding System [HCPCS] and/or International Classification of Diseases diagnoses codes), Type of Bill (TOB), revenue codes, occurrence codes, condition codes, and value codes.

The MAC systems shall be able to select claims for prepayment review using different types of comparisons. At a minimum, those comparisons shall include:

- Procedure to Procedure -permits contractor systems to screen multiple services at the claim level and in history.

- Procedure to Provider - permits selective screening of services that need review for a given provider.

- Frequency to Time- permits contractors to screen for a certain number of services provided within a given time period.

- Diagnosis to Procedure- permits contractors to screen for services submitted with a specific diagnosis. For example, the need for a vitamin B12 injection is related to pernicious anemia, absent 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 or TOB- permits contractors to screen services provided by a certain specialty or TOB.

- Procedure to Place of Service- permits selective screening of claims where the service was provided in a certain setting such as a comprehensive outpatient rehabilitation facility.

Additional MAC system comparisons shall include, but are not limited to the following:

- Diagnoses alone or in combination with related factors.

- Revenue linked to the health care common procedure coding system (HCPCS).

- Charges related to utilization, especially when the service or procedure has an established dollar or number limit.

- Length of stay or number of visits, especially when the service or procedure violates time or number limits.

- Specific providers alone or in combination with other parameters.

The MR edits are coded system logic that either automatically pays all or part of a claim, automatically denies all or part of a claim, or suspends all or part of a claim so that a trained clinician or claims analyst can review the claim and associated documentation (including documentation requested after the claim is submitted) in order to make determinations about coverage and payment under Section 1862(a) (1) (A) of the Act.
Namely, the claim is for a service or device that is medically reasonable and necessary to diagnose or treat an injury or improve the functioning of a malformed body member. All non-automated review work resulting from MR edits shall:

- Involve activities defined under the MIP at §1893(b)(1) of the Act;

- Be articulated in the MAC's medical review strategy;

- Be designed in such a way as to reduce the MAC's CERT error rate or prevent the MAC's

CERT error rate from increasing, or;

Prevent improper payments identified by the RACs.

3.2.2 - Provider Notice

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

This section applies to MACs, RACs, *UPICs*, and SMRC as indicated.

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

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

A. Notice of Provider-Specific Review

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

- The MAC has identified questionable billing practices (e.g., non-covered, incorrectly coded or incorrectly billed services) through data analysis;

- The MAC receives alerts from other MACs, Quality Improvement Organizations (QIOs), CERT, RACs, OIG/GAO, or internal/external components that warrant review;

- The MAC receives complaints; or,

- The MAC validates the items bulleted in §3.2.1.

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

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

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

MACs

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

RACs

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

Unified Program Integrity Contractor (UPIC)

The *UPICs* shall notify selected providers prior to beginning a provider-specific review by sending an individual written notice. *UPICs* shall indicate whether the review will occur on a prepayment or postpayment basis. *UPICs* shall maintain a copy of the letter and the date it was mailed. This notification shall be mailed the same day that the edit request is forwarded to the MAC. Refer to Exhibit 45 for the letter to be sent.

B. Notice of Service-Specific Review

This section applies to MACs, RACs and SMRC as indicated.

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

MACs

Web site postings

The MACs shall provide notification prior to beginning a service-specific review by posting a review description on their Web site. MACs should, at their discretion, state what additional documentation is needed from providers to make a claim determination on their Web site. MACs

shall keep the Web site current by posting active reviews.

MACs should, at their discretion, create an archive for old review topics that are no longer under active review. Active review is defined as the time period during which ADRs are sent, determinations are made and findings are communicated to the providers. MACs should categorize the active review topics by provider type.

Individual written notices

MACs have the discretion to also notify providers about a service-specific review by sending individual notices to the affected providers. MACs have the discretion to issue the notice separately or include it in the ADR. MACs should, at their discretion, state what additional documentation is needed from providers to make a claim determination in the written notices.

RACs

Before beginning widespread service-specific reviews, RACs shall notify the provider community that the RAC intends to initiate review of certain items/services through a posting on the RAC Web site describing the item/service that will be reviewed.

Additionally, for medical record reviews, the RACs shall send ADRs to providers that clearly articulate the items or services under review and indicate the appropriate documentation to be submitted.

Unified Program Integrity Contractors (UPICs)

The *UPICs* shall provide notification prior to beginning a service-specific review by sending individual written notices to the affected providers. This notification shall be mailed the same day that the edit request is forwarded to the MAC. The *UPICs* shall maintain a copy of the letter and the date it was mailed. Refer to Exhibit 45 for the letter to be sent.

SMRC

The SMRC shall operate/maintain a public Web site that displays what types of issues are under review. For each area, the SMRC shall include a link to the relevant OIG/GAO or other reports available. In addition to the Web site, the SMRC shall notify providers about a service-specific review by sending an ADR. The SMRC shall state what additional documentation is needed from providers to make a claim determination in the ADR.

3.2.2.1 - Maintaining Provider Information

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

This section applies to MAC.

A. Provider Tracking System (PTS)

The MACs shall have a PTS in place to identify and track all individual providers currently under action plans to correct identified problems, such, as not reasonable and necessary, incorrect coding, and inappropriate billing. MACs shall use the provider tracking system (PTS) to coordinate contacts with providers such as MR notifications, telephone calls directly related to probe reviews, and referrals to POE. The MACs shall ensure that if a provider is to be contacted as a result of more than one problem, redundant contacts are minimized. The MACs shall also coordinate corrective action information with the *UPICs* to ensure contacts are not in conflict with benefit integrity related activities. The MAC PTS shall contain the date a provider is put on a provider- specific edit. The MAC shall reassess all providers on provider-specific prepayment or postpayment review on a quarterly basis to determine whether the behavior has improved. The MAC shall note the results of these quarterly assessments in the PTS. If the behavior has improved sufficiently and the edit was turned off, note that date as well in the PTS. When a MAC becomes aware that the provider has appealed a medical review determination to an Administrative Law Judge (ALJ), the MAC should send a letter to the ALJ and describe the information in the PTS to demonstrate the corrective actions that have been taken by the MAC.

B. Recovery Auditor Case Files

The Recovery Auditor shall maintain case files following the guidelines in the Recovery Auditor SOW.

C. Provider Addresses

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

The MACs, CERT and Recovery Auditors shall mail the ADR to the best known address for the provider. MACs are encouraged to indicate the procedure a provider can follow to update address information in their ADRs and on their Web sites. If a provider wishes to have ADRs sent to one address but demand letters sent to a different address, MACs are encouraged to accommodate this request.

Note: Providers and suppliers must complete and submit a Medicare enrollment application (either the paper CMS-855 or a submission via Internet-based Provider Enrollment, Chain & Ownership [PECOS] to change existing information in the Medicare enrollment record.)

D. When the Provider or Supplier No Longer Occupies a Physical Address

This section applies to MACs and *UPICs*, as indicated.

When the MACs and *UPICs* become aware that the provider or supplier no longer occupies a physical address, any future correspondence shall reference only the claim control numbers and not list the individual beneficiary data (e.g., names and Medicare beneficiary identifiers). This process is contingent on current automated system limits.

The following are situations where the MAC and *UPIC* can assume the provider or supplier no longer occupies the last known location. This list is not exhaustive and the MACs and *UPICs* should use other means to confirm addresses, at their discretion.

- The MAC and *UPIC* receive mail that has been returned by the post office indicating no known address;

- An onsite visit has confirmed the address is vacant or is occupied by another occupant; or,

- A beneficiary complaint(s) is on record stating the provider or supplier is no longer at the address and follow up confirms the complaint.

In the above situations, correspondence from the MACs and *UPICs* shall only contain the claim control number and advise the provider or supplier to contact them for a list of the specific claims associated with the overpayment. This process will prevent the potential compromise of Medicare beneficiary names and/or Medicare beneficiary identifiers being sent to an abandoned address (or a location with a new occupant). If the letter is returned from the post office, maintain the notification on file for evidence.

3.2.3 - Requesting Additional Documentation During Prepayment and Postpayment Review

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

This section applies to MACs, CERT, RACs, and *UPICs*, as indicated.

A. General

In certain circumstances, the MACs, CERT, RACs, and *UPICs* may not be able to make a determination on a claim they have chosen for review based upon the information on the claim, its attachments, or the billing history found in claims processing system (if applicable) or the Common Working File (CWF). In those instances, the reviewer shall solicit documentation from the provider or supplier by issuing an additional documentation request (ADR). The term ADR refers to all documentation requests associated with prepayment review and postpayment review. MACs, CERT, RACs, and *UPICs* have the discretion to collect documentation related to the beneficiary's condition before and after a service in order to get a more complete picture of the beneficiary's clinical condition. The MAC, RAC, and *UPIC* shall not deny other claims submitted before or after the claim in question unless appropriate consideration is given to the actual additional claims and associated documentation. The CERT contractor shall solicit documentation in those circumstances in accordance with its Statement of Work (SOW).

The term "additional documentation" refers to medical documentation and other documents such as supplier/lab/ambulance notes and includes:

- Clinical evaluations, physician evaluations, consultations, progress notes, physician's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports. This documentation is maintained by the physician and/or provider.

- Supplier/lab/ambulance notes include all documents that are submitted by suppliers, labs, and ambulance companies in support of the claim (e.g., Certificates of Medical Necessity, supplier records of a home assessment for a power wheelchair).

- Other documents include any records needed from a biller in order to conduct a review and reach a conclusion about the claim.

NOTE: Reviewers shall consider documentation in accordance with other sections of this manual.

The MAC and *UPIC* have the discretion to deny other "related" claims submitted before or after

the claim in question, subject to CMS approval as described below. If documentation associated with one claim can be used to validate another claim, those claims may be considered "related." Approved examples of "related" claims that may be denied as "related" are in the following situations:

- When the Part A Inpatient surgical claim is denied as not reasonable and necessary, the MAC may recoup the surgeon's Part B services. For services where the patient's history and physical (H&P), physician progress notes or other hospital record documentation does not support the medical necessity for performing the procedure, postpayment recoupment may occur for the performing physician's Part B service.

- Reserved for future approved "related" claim review situations. The MAC shall report to their BFL and COR prior to initiating denial of "related" claims situations.

The MAC and *UPIC* shall await CMS approval prior to initiating requested "related" claim(s) review. Upon CMS approval, the MAC shall post the intent to conduct "related" claim review(s) to their Web site within 1 month prior to initiation of the approved "related" claim review(s). The MAC shall inform CMS of the implementation date of the "related" claim(s) review 1 month prior to the implementation date.

If "related" claims are denied automatically, MACs shall count these denials as automated review. If the "related" claims are denied after manual intervention, MACs shall count these denials as non-medical record review.

The RAC shall utilize the review approval process as outlined in their SOW when performing reviews of "related" claims.

The MAC, RAC, and *UPIC* are not required to request additional documentation for the "related" claims before issuing a denial for the "related" claims.

Contactors shall process appeals of the "related" claim(s) separately.

B. Authority to Collect Medical Documentation

Contractors are authorized to collect medical documentation by the Social Security Act. Section 1833(e) states "No payment shall be made to any provider of services or other person under this part unless there has been furnished such information as may be necessary in order to determine the amounts due such provider or other person under this part for the period with respect to which the amounts are being paid or for any prior period." Section 1815(a) states "…no such payments shall be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due such provider under this part for the period with respect to which the amounts are being paid or any prior period."

The OMB Paperwork Reduction Act collection number for prepayment medical review is 0938-0969. MACs shall use this number on every additional documentation request or any other type of written request for additional documentation for prepayment medical review. It can be in the header, footer or body of the document. CMS suggests the information read "OMB #: 0938-0969" or OMB Control #: 0938-0969." Postpayment medical review does not require an OMB control number.

C. PWK (Paperwork) Modifier

MAC medical review departments are only required to review unsolicited documentation when the claim suspends for a medical review edit/audit. MACs shall not send an ADR request for a claim with a PWK modifier until after review of the PWK unsolicited documentation or the waiting days have elapsed without receipt of documentation.

MACs shall allow 7 calendar "waiting days" (from the date of receipt of the claim) for additional unsolicited documentation to be submitted or 10 calendar "waiting" days for the unsolicited documentation to be mailed. Contractors serving island territories shall have the flexibility to adjust "waiting days" as is necessary. CMS expects that any adjustment from the core 7/10 days will be discussed with and approved by your contracting officer prior to implementation. When the documentation is received, the contractor has 30 calendar days to make a determination on the claim. If the contractor cannot make a determination on the claim after reviewing the unsolicited documentation submitted, they shall request additional documentation using their normal business procedures for ADR that are outlined in Chapter 3 of the Program Integrity Manual.

3.2.3.2 - Time - Frames for Submission

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

This section applies to MACs, RACs, CERT, and *UPICs*, as indicated.

A. Prepayment Review Time Frames

When requesting documentation for prepayment review, the MAC and *UPIC* shall notify providers that the requested documentation is to be submitted within 45 calendar days of the request. The reviewer should not grant extensions to providers who need more time to comply with the request. Reviewers shall deny claims for which the requested documentation was not received by day 46.

B. Postpayment Review Time Frames

When requesting documentation for postpayment review, the MAC, CERT and RAC shall notify providers that the requested documents are to be submitted within 45 calendar days of the request. *UPICs* shall notify providers that requested documents are to be submitted within 30 calendar days of the request. Because there are no statutory provisions requiring that postpayment review of the documentation be completed within a certain timeframe, MACs, CERT, and *UPICs* have the discretion to grant extensions to providers who need more time to comply with the request. The number of submission extensions and the number of days for each extension is solely within the discretion of the MACs, CERT and *UPICs*. RACs shall follow the time requirements outlined in their SOW.

C. For esMD submissions

The esMD review contractor shall use the Enterprise File Transfer (EFT) system receipt date as the date the documentation was received. If the EFT receipt date is outside of the contractors normal business hours, the following business day shall be used as the receipt date. Contractors shall pull for esMD files at least every 4 hours (business hours) daily; including a mandatory pulling between the hours of 6-7pm EST daily. If unforeseeable circumstances occur, in which contractors are not technically capable of retrieving documentation in a timely manner due to issues outside of their control, contractors are to notify the esMD Team and can use the date documentation was available to be retrieved once issues have been resolved in the EFT system.

3.2.3.3 - Third-party Additional Documentation Request

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

This section applies to MACs, RACs, CERT and *UPICs*, as indicated.

Unless otherwise specified, the MAC, RAC and *UPIC* shall request information from the billing provider/supplier. The treating physician, another clinician, provider, or supplier should submit the requested documentation. However, because the provider selected for review is the one whose payment is at risk, it is this provider who is ultimately responsible for submitting, within the established timelines, the documentation requested by the MAC, CERT, RAC and *UPIC*.

The CERT reviewer shall request medical record documentation from the referring provider as submitted/identified by National Provider Identifier/Unique Physician Identification Number on the claim when such information is not sent in by the billing supplier/provider initially and after a request for additional documentation fails to produce medical documentation necessary to support the service billed and supported by the Local and National Coverage Determinations.

The MAC, *UPIC* and RAC have the discretion to send a separate ADR to third- party entities involved in the beneficiary's care. They shall not solicit documentation from a third party unless they first or simultaneously solicit the same information from the billing provider or supplier. The following requirements also apply:

- The MACs, *UPICs* and RACs shall notify the third party and the billing provider or supplier that they have 30 calendar days to respond for a prepayment review or 45 calendar days for a postpayment review for MACs and RACs and 30 calendar days for *UPICs*.

- For prepayment review, the MACs and *UPICs* shall pend the claim for 45 calendar days. This 45 day time period may run concurrently as the 45 days that the billing provider or supplier has to respond to the ADR letter;

- The MACs and *UPICs* have the discretion to issue as many reminder notices as they deem appropriate to the third party via email, letter or phone call prior to the 30th or 45th calendar day, as discussed above;

- When information is requested from both the billing provider or supplier and a third party and a response is received from one or both that fails to support the medical necessity of the service, the MACs and *UPICs* shall deny the claim, in full or in part, using the appropriate denial code. Contractors shall count these denials as medical record reviews.

- Contractors shall include language in the denial notice reminding providers that beneficiaries cannot be held liable for these denials unless they received proper liability notification before services were rendered, as detailed in CMS Pub.100- 04, Medicare Claims Processing Manual, chapter 30.

- Refer to§3.2.3.7 for ADR to ordering providers for lab services.

3.2.3.5 - Acceptable Submission Methods for Responses to ADRs

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

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

Reviewers shall be clear in their ADR letters about what documentation submission methods they will accept from a provider or Health Information Handler (HIH). The MACs, CERT, and Recovery Auditors shall accept documents via paper, fax, CD/DVD, and electronic submission of medical documentation (esMD).

A. Paper

The MACs, CERT, and Recovery Auditors are encouraged to state in the ADRs that paper medical documentation can be mailed by any means including US Postal Service, FedEx, UPS, or certified mail. To facilitate delivery of documentation, MACs, CERT and Recovery Auditors should provide a physical mailing address instead of a P.O. Box.

B. Fax

If the MACs, CERT, or Recovery Auditors have the capability to offer fax confirmation, they are encouraged to send such confirmations with every successfully received fax.

C. Imaged Medical Documentation File(s) Sent on CD/DVD

The MACs and CERT shall state in the ADR that imaged medical documentation files on CD/DVD may be mailed by any means. Recovery Auditor ADRs shall provide a Web site link or phone number that provides information regarding the requirements for submitting imaged documentation on CD or DVD.

D. Medical Documentation Sent via Electronic Submission of Medical Documentation (esMD) Transmission

Electronic Submission of Medical Documentation (esMD) is a system that allows providers/HIHs to submit medical documentation over secure electronic means. Information about the esMD system can be found at www.cms.gov/esMD.

MACs and CERT are encouraged to state in their ADRs how providers can get more information about submitting medical documentation via the esMD mechanism.

Any time a new esMD service or document type is being offered, and any contractor wants to publish a public announcement (Web posting, list serve, tweet, etc.) the contractor must clear the announcement with CMS.

3.2.3.7 - Special Provisions for Lab Additional Documentation Requests

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

This section applies to MACs, CERT, RACs, *UPICs*, and SMRC as indicated.

ICD-10-CM is used for diagnoses on inpatient discharges and for other services provided upon implementation of ICD-10. ICD-9-CM is used for discharges and other services before that implementation.

When the MACs, CERT, RACs, and *UPICs* send an ADR for a lab service, the following documentation shall be requested from the billing lab:

- The order for the service billed (including sufficient information to allow the reviewer to

identify and contact the ordering provider);

- Verification of accurate processing of the order and submission of the claim; and

- Diagnostic or other medical information supplied to the lab by the ordering provider, including any diagnosis codes or narratives.

The contractor shall deny the claim if a benefit category, statutory exclusion, or coding issue is in question, or send an ADR to the ordering provider in order to determine medical necessity. The contractor shall review information from the lab and find it insufficient before the ordering provider is contacted. The contractor shall send an ADR to the ordering provider that shall include sufficient information to identify the claim in question.

If the documentation received does not demonstrate that the service was reasonable and necessary, the contractor shall deny the claim. These denials count as medical record reviews. Contractor denial notices shall remind providers that beneficiaries cannot be held liable for these denials unless they have received proper liability notification before services were rendered, as detailed in CMS Pub. IOM 100-04, chapter 30.

3.2.3.8 - No Response or Insufficient Response to Additional Documentation Requests

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

This section applies to MACs, RACs, CERT, and *UPICs*, as indicated.

A. Additional Documentation Requests

If information is requested from both the billing provider or supplier and a third party and no response is received from either within 45 calendar days for MACs and RACs or 30 calendar days for *UPICs* after the date of the request (or within a reasonable time following an extension), the MACs, RACs and *UPICs* shall deny the claim, in full or in part, as not reasonable and necessary. Contractors shall use Group Code: CO - Contractual Obligation and Claim Adjustment Reason Code (CARC) 50 - these are non- covered services because this is not deemed a “medical necessity” by the payer and Remittance Advice Remark Code (RARC) M127 - Missing patient medical record for this service.

Contractors shall count these denials as automated review or non-medical record review depending whether the denial is automated or requires manual intervention. For claims that had a PWK modifier, and the unsolicited documentation was reviewed, the review shall be counted as medical record review.

B. No Response

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

During postpayment review, if no response is received within 45 calendar days after the date of the ADR (or extension), the MACs shall deny the claim as not reasonable and necessary and count these denials as non-medical record reviews. *UPICs* shall deny the claim as not meeting reasonable and necessary criteria if no response is received within 30 calendar days. RACs shall count these as complex or non-complex reviews.

C. Insufficient Response

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

3.2.3.9 - Reopening Claims with Additional Information or Denied due to Late or No Submission of Requested Information

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

Contractors shall make available general reopening process information via their website, in their ADR letters, or through remittance advice notices.

If the MACs receive the requested information from a provider or supplier after a denial has been issued but within a reasonable number of days (generally 15 calendar days after the denial date), they have the discretion to reopen the claim. MACs who choose to reopen a specific claim shall notify the provider or supplier of their intent to reopen that claim. Notification to the provider/supplier of the intent to reopen a specific claim shall be completed through any of the following mechanisms: Interactive Voice Response (IVR), contractor website portal, telephone contact, by letter, fax, email or secure messaging within 3 business days of identification of the request to reopen or receipt of medical record documentation. MR will make an MR determination on the lines previously denied due to failure to submit requested documentation, and do one of the following, within 60 calendar days of receiving documentation in the mailroom:

- For claims originally selected for postpayment review, the reviewer shall issue a new letter containing the revised denial reason and the information required by PIM chapter 3 §3.6.4;

- For claims originally selected for prepayment review, the MAC shall enter the revised MR determination into the shared system, generating a new Medicare Summary Notice (MSN) and remittance advice with the new denial reason and appeals information;

- The workload, costs, and savings associated with this activity shall be allocated to the appropriate MR activity (e.g., MR reopenings);

In cases where the MAC or *UPIC* denied a claim and the denial is appealed, the appeals entity will send the claim to the contractor's MR department for reopening in accordance with CMS Pub. IOM 100-04, chapter 34, § 10.3. The claim sent back to the contractor's MR department must have been denied using Group Code: CO - Contractual Obligation and Claim Adjustment Reason Code (CARC) 50 - these are non-covered services because this is not deemed a "medical necessity" by the payer and Remittance Advice Remark Code (RARC) M127 - Missing patient medical record for this service. The MR department of the contractor (AC, MAC, or *UPIC*) who initiated the prepayment edit shall be responsible for conducting the reopening.

- The MACs who choose not to reopen claims when documentation is received past the deadline shall retain the information (hardcopy or electronic) in a location where it can be easily accessed.

If the RAC receives requested documentation from a supplier after a denial has been issued they shall not reopen the claim.

- If a RAC receives documentation after the submission deadline, but before they have issued a demand letter, the RAC shall review and consider the late documentation when making a claim determination;

- If the RAC receives a late response to a documentation request after they have issued a demand letter, the RAC shall retain the documentation so that it is available for review during the appeal process.

For information on how CERT handles late documentation, please refer to Chapter 12, Section 12.3.9.

3.2.3.10 - Record Retention and Storage

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

The MACs, CERT, and *UPICs* shall abide by all documentation retention requirements listed in all litigation holds issued via Joint Signature Memoranda or Technical Direction Letters (JSM/TDL). Recovery Auditors shall comply with the record retention requirements in its SOWs.

3.3 - Policies and Guidelines Applied During Review

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

This section applies to MACs, CERT, Recovery Auditors, Supplemental Medical Review Contractors (SMRCs) and *UPICs*, as indicated.

A. Statutes, Regulations, the CMS' Rulings, National Coverage Determinations, Coverage Provisions in Interpretive Medicare Manuals, and Local Coverage Determinations

The primary authority for all coverage provisions and subsequent policies is the Social Security Act. In general, MACs, CERT, Recovery Auditors, SMRCs, and *UPICs* shall apply the provisions of the Act according to the following hierarchy of documents in effect at the time the item(s) or service(s) was provided to make medical review decisions:

Social Security Act
Code of Federal Regulations
CMS' Rulings
National Coverage Determination (NCDs)
Coverage provisions in Interpretive Manuals or Internet Only Manuals (IOM) which includes Medical Review Guidance in the Medicare Program Integrity Manual.
CMS coding policies
Technical Direction Letters (TDLs)* The relevant MAC's Local Coverage Determination (LCDs). The relevant MAC's local articles
AHA Coding Clinics.

*TDLs that contain MR guidance may provide an exception to this hierarchy.

B. Coding Guidelines

The MACs, CERT, Recovery Auditors, and *UPICs* shall apply coding guidelines to services selected for review. All contractors shall determine that an item/service is correctly coded when it meets all the coding guidelines listed in the Current Procedural Terminology-4 (CPT) book, International Classification of Diseases Guidelines (ICD), CMS HCPCS or ICD policy or guideline requirements, LCDs, or MAC articles.

C. Internal Medical Review Guidelines

The MAC, CERT, Recovery Auditor, and *UPIC* staffs have the discretion to develop detailed written review guidelines to guide staff during claim reviews. Internal MR guidelines shall specify the information to be reviewed by reviewers and the appropriate resulting determination. Recovery Auditors are required to develop written review guidelines in accordance with their SOW. The MACs, CERT, Recovery Auditors, and *UPICs* shall make their internal MR guidelines available to their staff, as needed. Internal MR Guidelines shall not create or change the CMS policy.

3.3.1 - Types of Review: Medical Record Review, Non-Medical Record Review, and Automated Review

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

This section applies to MACs, CERT, SMRC, and *UPICs*, as indicated.

A. General

Most of the claim review activities completed for the purpose of identifying inappropriate billing and avoiding improper payments are divided into three distinct types: Medical Record Review, Non-Medical Record Review, and Automated Review.

The chart below indicates which contractors perform which types of review:

	Prepayment			**Postpayment**	
Contractor Type	Medical Record Review	Non-Medical Record Review	Automated Reviews	Medical Record Review	Non-Medical Record review
MACs	Yes	Yes	Yes	Yes	Yes
CERT	No	No	No	Yes	No
RACs	No	No	No	Yes	No
SMRC	No	No	No	Yes	Yes
UPIC	Yes	No	No	Yes	Yes

3.3.1.1 - Medical Record Review

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

This section applies to MACs, CERT, RACs, Supplemental Medical Review Contractor(s) and *UPICs*, as indicated.

A. Definition

Medical record review involves requesting, receiving, and reviewing medical documentation associated with a claim.

Medical record review, for the purpose of determining medical necessity, requires a licensed medical professional to use clinical review judgment to evaluate medical record documentation.

B. Clinical Review Judgment

Clinical review judgment involves two steps:

1. The synthesis of all submitted medical record information (e.g. progress notes, diagnostic findings, medications, nursing notes, etc.) to create a longitudinal clinical picture of the patient; and

2. The application of this clinical picture to the review criteria is to make a reviewer determination on whether the clinical requirements in the relevant policy have been met. MAC, CERT, RAC, and *UPIC* clinical review staff shall use clinical review judgment when making medical record review determinations about a claim.

Clinical review judgment does not replace poor or inadequate medical records. Clinical review judgment by definition is not a process that MACs, CERT, RACs and *UPICs* can use to override, supersede or disregard a policy requirement. Policies include laws, regulations, the CMS' rulings, manual instructions, MAC policy articles attached to an LCD or listed in the Medicare Coverage Database, national coverage decisions, and local coverage determinations.

C. Credentials of Reviewers

The MACs, MRAC, and CERT shall ensure that medical record reviews for the purpose of making coverage determinations are performed by licensed nurses (RNs), therapists or physicians. Current LPNs may be grandfathered in and can continue to perform medical record review. The MACs, MRAC, and CERT shall not hire any new LPNs to perform medical record review. *UPICs*, RACs and the SMRC shall ensure that the credentials of their reviewers are consistent with the requirements in their respective SOWs.

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

RACs shall ensure that a licensed medical professional will perform medical record reviews for the purpose of determining medical necessity, using their clinical review judgment to evaluate medical record documentation. Certified coders will perform coding determinations. CERT and MACs are encouraged to make coding determinations by using certified coders. *UPICs* have the discretion to make coding determinations using certified coders.

D. Credential Files

The MACs, MRAC, CERT, RACs, and *UPICs* shall maintain a credentials file for each reviewer

(including consultants, contract staff, subcontractors, and temporary staff) who performs medical record reviews. The credentials file shall contain at least a copy of the reviewer's active professional license.

E. Quality Improvement (QI) Process

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

F. Advanced Beneficiary Notice (ABN)

The MACs, CERT, RACs, *UPICs*, and SMRCs shall request as part of the ADR, during a medical record review, a copy of any mandatory ABNs, as defined in Pub. 100- 04, Medicare Claims Processing Manual Chapter 30 section 50.3.1. If the claim is determined not to be reasonable and necessary, the contractor will perform a face validity assessment of the ABN in accordance with the instructions stated in Pub. 100-04 Medicare Claims Processing Manual chapter 30 section 50.6.3.

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

G. MAC Funding Issues

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

All medical record review work performed by MACs shall:

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

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

H. Review Timeliness Requirements

<u>Prepayment Review Requirements for MACs</u>

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

Counting the 30 Calendar Day Timeframe

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

Prepayment Review Requirements for *UPICs*

When a *UPIC* receives all documentation requested for prepayment review within 45 calendar days of the date of the ADR, the *UPIC* shall make and document the review determination and notify the MAC of its determination within 60 calendar days of receiving all requested documentation. Medical review for the purpose of fraud, waste, or abuse requires 60 days to allow for the integration of information from the investigative process. This information may be a result of recent/concurrent investigative actions such as beneficiary/provider/supplier interviews, site visits and/or receipt of additional internal/external information.

Postpayment Review Requirements for MACs

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

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

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

Postpayment Review Requirements for RACs

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

State Laws that Affect Prepayment Review Timeliness Requirements

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

next business day.

Postpayment Review Requirements for *UPICs*

To promote the timeliness of the investigative process, the *UPICs* shall complete postpayment medical review and provide the lead investigator with a final summary of the medical review findings that includes reference to the allegations being substantiated/not substantiated by medical review, reasons for denials, and any observations or trends noted within 60 calendar days, unless otherwise directed by CMS. The counting for the 60-day time period begins when all of the documentation is received by the *UPIC*. The *UPIC* shall have a HIPAA compliant process to receive this documentation that includes the application of the date the documents are received at the *UPIC's* designated mailing address for all methods described in section 3.2.3.5 of this chapter. The medical review unit shall communicate the medical review findings in a summary document to the investigative lead within 60 calendar days of receiving all of the requested documentation. Medical review for the purpose of fraud, waste, or abuse requires 60 days to allow for the integration of information from the investigative process. This information may be a result of recent/concurrent investigative actions such as beneficiary/provider/supplier interviews, site visits and/or receipt of additional internal/external information.

If the *UPIC* is unable to complete the postpayment medical review in 60 days, they shall communicate this to their COR and request an extension. This approval must be documented in the case management system by the contactor.

3.3.1.2 - Non-Medical Record Review

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

This section applies to MACs, SMRC, and *UPICs*, as indicated.

A. Definition

Non-medical record reviews uses manual intervention, but only to the extent a reviewer can make a determination based on information on a claim. It does not require clinical judgment in review of medical record documentation. Contractors shall only perform a non-medical record review for denials of related claims and/or no receipt of ADR documentation where such denials cannot be automated.

3.3.1.3 - Automated Review

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

A. Definition

A medical review is considered automated when a payment decision is made at the system level, using available electronic information, with no manual intervention.

CERT refers to all reviews where no documentation was requested as "T-claim review." T-claims are a particular category of claim reviewed by CERT. T-claims are claims that were automatically denied by the MAC.

B. Basis for Automated Reviews

The MAC, RAC, CERT, SMRC, and *UPIC* shall ensure that automated prepayment and

postpayment denials are based on clear policy that serves as the basis for denial; or a Medically Unlikely Edit (MUE); or occurs when no timely response is received to an ADR.

When a clear policy exists (or in the case of a MUE), MACs, RACs, SMRC, and *UPICs* have the discretion to automatically deny the services without stopping the claim for manual review, even if documentation is attached or simultaneously submitted. Reviewers shall still make a determination based on the liability limitations of §1879 of the Act. The term "clear policy" means a statute, regulation, NCD, coverage provision in an interpretive manual, coding guideline, LCD or MAC article that specifies the circumstances under which a service will always be considered non-covered, incorrectly coded, or improperly billed.

A MUE is a unit of service (UOS) edit for a Healthcare Common Procedure Coding system (HCPCS)/Current Procedural Terminology (CPT) code for services rendered by a single provider/supplier to a single beneficiary on the same date of service. The ideal MUE is the maximum UOS that would be reported for a HCPCS/CPT code on the vast majority of appropriately reported claims. The MUE program provides a method to report medically reasonable and necessary UOS in excess of a MUE.

Automated edits can be used for apparent typographical errors (e.g., 10,000 blood cultures for the same beneficiary on the same day).

MACs shall implement automated prepayment review whenever appropriate.

The RACs refer to all reviews where no documentation was requested as "automated review."

3.3.2 - Medical Review Guidance

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

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

This section describes the requirements that MACs, CERT, Recovery Auditors, and *UPICs* shall follow when reviewing submitted documentation. Additional requirements for *UPICs* are located in PIM chapter 4. When *UPIC* staff is performing benefit integrity reviews, their focus is different than that of MACs, CERT, and Recovery Auditors. For example, *UPIC* staff looks for some of the following situations when reviewing documentation:

- Possible falsification or other evidence of alterations including, but not limited to: obliterated sections; missing pages, inserted pages, white out; and excessive late entries;

- Evidence that the service billed for was actually provided; or,

- Patterns and trends that may indicate potential fraud.

3.3.2.2 - Absolute Words and Prerequisite Therapies

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

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

The MACs, CERT, Recovery Auditors, and *UPICs* shall not deviate from coverage provisions if absolute words such as "never" or "only if" are used when making claim determinations where a regulation, CMS ruling, NCD, LCD, or MAC policy article exists. In these cases, reviewers shall

not make any exceptions or give individual consideration.

Requirements for prerequisite therapies shall be followed when deciding whether to cover a service if listed in coverage provisions in interpretive manuals (e.g., “conservative treatment has been tried, but failed”).

3.3.2.3 - Mandatory Policy Provisions

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

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

CERT contractors select claims for review on a random basis and do not select claims that are suspect. The CERT reviewers shall review every line on the randomly selected claim that affects payment to determine if the following types of requirements are met:

- Coding requirements;
- Benefit category requirements;
- The reasonable and necessary requirements of the NCDs and LCDs, among others.

The MACs and *UPICs* select claims to prevent or identify an improper payment. They are only required to review the suspect line and not every line on the selected claims. The selected line does not need to be completely reviewed. Along with reviewing the line for coding accuracy, the MACs should review for medical necessity if the provider has been notified that both types of review will occur. The *UPICs* shall use discretion in notifying the provider.

3.3.2.4 - Signature Requirements

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

This section is applicable for Medicare Administrative Contractors (MACs), *Unified Program Integrity Contractors (UPICs)*, Supplemental Medical Review Contractors (SMRCs), Comprehensive Error Rate Testing (CERT), and Recovery Audit Contractor (RACs), as indicated.

For medical review purposes, Medicare requires that services provided/ordered/certified be authenticated by the persons responsible for the care of the beneficiary in accordance with Medicare’s policies. For example, if the physician’s authenticated documentation corroborates the nurse’s unsigned note, and the physician was the responsible party per Medicare’s payment policy, medical reviewers would consider signature requirements to have been met. The method used shall be a handwritten or electronic signature. Stamped signatures are not acceptable.

NOTE: Scribes are not providers of items or services. When a scribe is used by a provider in documenting medical record entries (e.g. progress notes), CMS does not require the scribe to sign/date the documentation. The treating physician’s/non-physician practitioner’s (NPP’s) signature on a note indicates that the physician/NPP affirms the note adequately documents the care provided. Reviewers are only required to look for the signature (and date) of the treating physician/non-physician practitioner on the note. Reviewers shall not deny claims for items or services because a scribe has not signed/dated a note.

EXCEPTION 1: Facsimiles of original written or electronic signatures are acceptable for the certifications of terminal illness for hospice.

EXCEPTION 2: There are some circumstances for which an order does not need to be signed. For example, orders for some clinical diagnostic tests are not required to be signed. The rules in 42 CFR 410 and Pub.100-02 chapter 15, §80.6.1 state that if the order for the clinical diagnostic test is unsigned, there must be medical documentation (e.g., a progress note) by the treating physician that he/she intended the clinical diagnostic test be performed. This documentation showing the intent that the test be performed must be authenticated by the author via a handwritten or electronic signature.

EXCEPTION 3: Other regulations and the CMS' instructions regarding conditions of payment related to signatures (such as timeliness standards for particular benefits) take precedence. For medical review purposes, if the relevant regulation, NCD, LCD and CMS manuals are silent on whether the signature needs to be legible or present and the signature is illegible/missing, the reviewer shall follow the guidelines listed below to discern the identity and credentials (e.g., MD, RN, etc.) of the signator. In cases where the relevant regulation, NCD, LCD and CMS manuals have specific signature requirements, those signature requirements take precedence.

EXCEPTION 4: CMS would permit use of a rubber stamp for signature in accordance with the Rehabilitation Act of 1973 in the case of an author with a physical disability that can provide proof to a CMS contractor of his/her inability to sign their signature due to their disability. By affixing the rubber stamp, the provider is certifying that they have reviewed the document.

NOTE: Conditions of participation (COP) are not conditions of payment.

If MAC and CERT reviewers find reasons for denial unrelated to signature requirements, the reviewer need not proceed to signature authentication. If the criteria in the relevant Medicare policy cannot be met but for a key piece of medical documentation that contains a missing or illegible signature, the reviewer shall proceed to the signature assessment.

Providers should not add late signatures to the medical record, (beyond the short delay that occurs during the transcription process) but instead should make use of the signature authentication process. The signature authentication process described below should also be used for illegible signatures.

A. Handwritten Signature

A handwritten signature is a mark or sign by an individual on a document signifying knowledge, approval, acceptance or obligation.

- If the signature is illegible, MACs, *UPICs*, SMRC, and CERT shall consider evidence in a signature log, attestation statement, or other documentation submitted to determine the identity of the author of a medical record entry.

- If the signature is missing from an order, MACs, SMRC, and CERT **shall disregard the order** during the review of the claim (e.g., the reviewer will proceed as if the order was not received).

- If the signature is missing from any other medical documentation (other than an order), MACs, SMRC, and CERT shall accept a signature attestation from the author of the medical record entry.

B. Signature Log

Providers will sometimes include a signature log in the documentation they submit that lists the typed or printed name of the author associated with initials or illegible signature. The signature log might be included on the actual page where the initials or illegible signature are used or might be a separate document. Reviewers should encourage providers to list their credentials in the log. However, reviewers shall not deny a claim for a signature log that is missing credentials. Reviewers shall consider all submitted signature logs regardless of the date they were created. Reviewers are encouraged to file signature logs in an easily accessible manner to minimize the cost of future reviews where the signature log may be needed again.

C. Signature Attestation Statement

Providers will sometimes include an attestation statement in the documentation they submit. In order to be considered valid for Medicare medical review purposes, an attestation statement must be signed and dated by the author of the medical record entry and must contain sufficient information to identify the beneficiary.

Should a provider choose to submit an attestation statement, they may choose to use the following statement:

"I, [print full name of the physician/practitioner], hereby attest that the medical record entry for [date of service] accurately reflects signatures/notations that I made in my capacity as [insert provider credentials, e.g., M.D.] when I treated/diagnosed the above listed Medicare beneficiary. I do hereby attest that this information is true, accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability."

Although this format is acceptable, the CMS currently neither requires nor instructs providers to use a certain form or format. A general request for signature attestation shall be considered a non-standardized follow-up question from the contractors to the providers. However, since no form for signature attestation has been approved by the Office of Management and Budget (OMB), the contractors should not give the providers any standard format on which to submit the attestation. Once the OMB has assigned an OMB Paperwork Reduction Act number to this attestation form, its use will be mandatory.

Note: The MACs and CERT shall NOT consider attestation statements where there is no associated medical record entry. Reviewers shall NOT consider attestation statements from someone other than the author of the medical record entry in question (even in cases where two individuals are in the same group, one should not sign for the other in medical record entries or attestation statements). Reviewers shall consider all attestations that meet the above requirements regardless of the date the attestation was created, except in those cases where the regulations or policy indicate that a signature must be in place prior to a given event or a given date. For example, if a policy states the physician must sign the plan of care before therapy begins, an attestation can be used to clarify the identity associated with an illegible signature. However, such attestation cannot be used to "backdate" the plan of care.

D. Signature Guidelines

The guidelines below will assist in determining whether to consider the signature requirements met:

- In the situations where the guidelines indicate **"signature requirements met,"**

the reviewer shall consider the entry.

- In situations where the guidelines indicate **"contact billing provider and ask a non-standardized follow up question,"** the reviewer shall contact the person or organization that billed the claim and ask if the billing entity would like to submit an attestation statement or signature log within 20 calendar days. The 20 day timeframe begins on the date of the telephone contact with the provider or on the date the request letter is received by the provider. If the biller submits a signature log or attestation, the reviewer shall consider the contents of the medical record entry.

- In cases where a reviewer has requested a signature attestation or log, the time for completing the review is extended by 15 days. This extension starts upon receipt of the signature attestation or log.

- The MACs, CERT and *UPICs* shall document all contacts with the provider and/or other efforts to authenticate the signature.

Note: The MACs, CERT and *UPICs* shall **NOT** contact the **biller when the claim should be denied for reasons unrelated** to the signature requirement.

		Signature Requirement Met	Contact billing provider and ask a non- standardized follow up question
1	Legible full signature	X	
2	Legible first initial and last name	X	
3	Illegible signature over a typed or printed name Example:  John Whigg, MD	X	
4	Illegible signature where the letterhead, addressograph or other information on the page indicates the identity **o**f the signatory. Example: An illegible signature appears on a prescription. The letterhead of the prescription lists (3) physicians' names. One of the names is circled.	X	
5	Illegible signature NOT over a typed/printed name and NOT on letterhead, but the submitted documentation **is accompanied** by: a signature log, or an attestation statement	X	
6	Illegible signature NOT over a typed/printed name, NOT on letterhead and the documentation is **UNaccompanied** by: a signature log, or an attestation statement Example:		X
7	Initials over a typed or printed name	X	
8	Initials NOT over a typed/printed name but **accompanied** by: a signature log, or an attestation statement	X	
9	Initials NOT over a typed/printed name **UNaccompanied** by: a signature log, or an attestation statement		X
10	Unsigned typed note with provider's typed name		X

	Example: John Whigg, MD		
11	Unsigned typed note without providers typed/printed name		X
12	Unsigned handwritten note, the only entry on the page		X
13	Unsigned handwritten note where other entries on the same page in the same handwriting are signed.	X	
14	"signature on file"		X

E. Electronic Signatures

Providers using electronic systems need to recognize that there is a potential for misuse or abuse with alternate signature methods. For example, providers need a system and software products that are protected against modification, etc., and should apply adequate administrative procedures that correspond to recognized standards and laws. The individual whose name is on the alternate signature method and the provider bear the responsibility for the authenticity of the information for which an attestation has been provided. Physicians are encouraged to check with their attorneys and malpractice insurers concerning the use of alternative signature methods.

F. Electronic Prescribing

Electronic prescribing (e-prescribing) is the transmission of prescription or prescription- related information through electronic media. E-prescribing takes place between a prescriber and dispenser, pharmacy benefit manager (PBM), or health plan. It can take place directly or through an e-prescribing network. With e-prescribing, health care professionals can electronically transmit both new prescriptions and responses to renewal requests to a pharmacy without having to write or fax the prescription. E-prescribing can save time, enhance office and pharmacy productivity, and improve beneficiary safety and quality of care.

A "qualified" e-prescribing system is one that meets the Medicare Part D requirements described in 42 CFR 423.160 (Standards for Electronic Prescribing).

1. E-Prescribing for Part B Medications (Other than Controlled Substances)

The MAC, CERT and *UPIC* reviewers shall accept as a valid order any Part B medications, other than controlled substances, ordered through a qualified e-prescribing system. For Medicare Part B medical review purposes, a qualified e-prescribing system is one that meets all 42 CFR §423.160 requirements. When Part B medications have been ordered through a qualified e-prescribing system, the reviewer shall NOT require the provider to produce hardcopy pen and ink signatures as evidence of a medication order.

2. E-Prescribing for Part B Controlled Substance Medications

Historically, the Drug Enforcement Agency (DEA) has not permitted the prescribing of controlled substance medications through e-prescribing systems. Therefore, when reviewing claims for controlled substance medications, MAC, CERT and *UPICs* reviewers shall only accept hardcopy pen and ink signatures as evidence of a medication order. However, the DEA is in the process of establishing requirements for electronic prescriptions for controlled substances. Refer to 21 CFR§§1300, 1304, 1306 and 1311 for further information.

3. E-Prescribing for Medications Incident to DME

The MAC, CERT and *UPICs* reviewers shall accept as valid any e-prescribed order for medications incident to Durable Medical Equipment (DME), other than controlled substances. For the purpose of conducting Medicare medical review of medications incident to DME, a qualified e-prescribing system is one that meets all §42 CFR 423.160 requirements. When medications incident to DME have been ordered through a qualified e-prescribing system, the reviewer shall NOT require the provider to produce hardcopy pen and ink signatures as evidence of a medication order.

G. Additional Signature Requirements for Durable Medical Equipment, Prosthetics, Orthotics, & Supplies (DMEPOS)

Refer to PIM chapter 5 for further details regarding additional signature requirements for DMEPOS.

H. Signature Dating Requirements

For medical review purposes, if the relevant regulation, NCD, LCD and other CMS manuals are silent on whether the signature must be dated, the MACs, CERT and *UPICs* shall ensure that the documentation contains enough information for the reviewer to determine the date on which the service was performed/ ordered.

Example: The claim selected for review is for a hospital visit on October 4. The ADR response is one page from the hospital medical record containing three (3) entries. The first entry is dated October 4 and is a physical therapy note. The second entry is a physician visit note that is undated. The third entry is a nursing note dated October 4. The reviewer should conclude that the physician visit was conducted on October 4.

I. Additional Documentation Request Language Regarding Signatures

The CERT contractor shall use language in its ADR letters reminding providers that the provider may need to contact another entity to obtain the signed version of a document. For example, a hospital discharge summary in the physician's office files may be unsigned, whereas the version of the discharge summary in the hospital files should be signed and dated. MACs are encouraged to use such language in their letters. In addition, MACs, CERT and *UPICs* have the discretion to add language to their ADRs stating that the provider is encouraged to review their documentation prior to submission, to ensure that all services and orders are signed appropriately. In cases where a reviewer finds a note with a missing or illegible signature, the ADR may inform the provider that it should submit a signature log or signature attestation as part of the ADR response.

The following is sample language that reviewers may choose to use in certain ADRs:

"Medicare requires that medical record entries for services provided/ordered be authenticated by the author. The method used shall be a handwritten or electronic signature. Stamp signatures are not acceptable. Beneficiary identification, date of service, and provider of the service should be clearly identified on the submitted documentation.

The documentation you submit in response to this request should comply with these requirements. This may require you to contact the hospital or other facility where you provided the service and obtain your signed progress notes, plan of care, discharge summary, etc.

If you question the legibility of your signature, you may submit an attestation statement in your ADR response.

If the signature requirements are not met, the reviewer will conduct the review without considering the documentation with the missing or illegible signature. This could lead the reviewer to determine that the medical necessity for the service billed has not been substantiated."

J. Potential Fraud Referrals

At any time, suspected fraud shall result in a referral to the *UPIC* for development. If MAC, RAC, SMRC or CERT reviewers identify a pattern of missing/illegible signatures, the reviewer shall refer to the appropriate *UPIC* for further development.

3.3.2.5 - Amendments, Corrections and Delayed Entries in Medical Documentation

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

This section applies to MACs, CERT, Recovery Auditors, SMRC and *UPICs*, as indicated.

A. Amendments, Corrections and Delayed Entries in Medical Documentation

All services provided to beneficiaries are expected to be documented in the medical record at the time they are rendered. Occasionally, certain entries related to services provided are not properly documented. In this event, the documentation will need to be amended, corrected, or entered after rendering the service. When making review determinations the MACs, CERT, Recovery Auditors, SMRC and *UPICs* shall consider all submitted entries that comply with the widely accepted Recordkeeping Principles described in section B below. The MACs, CERT, Recovery Auditors, SMRC and *UPICs* shall NOT consider any entries that do not comply with the principles listed in section B below, even if such exclusion would lead to a claim denial. For example, they shall not consider undated or unsigned entries handwritten in the margin of a document. Instead, they shall exclude these entries from consideration.

B. Recordkeeping Principles

Regardless of whether a documentation submission originates from a paper record or an electronic health record, documents submitted to MACs, CERT, Recovery Auditors, SMRC and *UPICs* containing amendments, corrections or addenda must:

1. Clearly and permanently identify any amendment, correction or delayed entry as such*;*
2. Clearly indicate the date and author of any amendment, correction or delayed entry*;* and

3. Clearly identify all original content, without deletion.

Paper Medical Records: When correcting a paper medical record, these principles are generally accomplished by:

1. Using a single line strike through so the original content is still readable, and

2. The author of the alteration must sign and date the revision.

Amendments or delayed entries to paper records must be clearly signed and dated upon entry into the record. Amendments or delayed entries to paper records may be initialed and dated if the medical record contains evidence associating the provider's initials with their name. For example, if the initials match the first and last name of the practitioner documented elsewhere in the medical records including typed or written identifying information, the reviewer shall accept the entry.

Electronic Health Records (EHR): Medical record keeping within an EHR deserves special considerations; however, the principles specified above remain fundamental and necessary for document submission to MACs, CERT, Recovery Auditors, SMRC and *UPICs*. Records sourced from electronic systems containing amendments, corrections or delayed entries must:

a. Distinctly identify any amendment, correction or delayed entry, and*;*
b. Provide a reliable means to clearly identify the original content, the modified content, and the date and authorship of each modification of the record.

C. If the MACs, CERT, SMRC or Recovery Auditors identify medical documentation with potentially fraudulent entries, the reviewers shall refer the cases to the *UPIC* and may consider referring to the RO and State Agency.

3.3.2.6 - Psychotherapy Notes

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

This section applies to MACs, CERT, Recovery Auditors or *UPICs*, as indicated.

Psychotherapy notes are defined in 45 CFR§164.501 as "notes recorded by a mental health professional which document or analyze the contents of a counseling session and that are separated from the rest of a medical record." The definition of psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of administered treatment, results of clinical tests, and any summary of diagnosis, functional status, treatment plan, symptoms prognosis, ongoing progress and progress to date. This class of information does not qualify as psychotherapy note material. Physically integrating information excluded from the definition of psychotherapy notes and protected information into one document or record does not transform the non-protected information into protected psychotherapy notes.

Under no circumstances shall the MACs, CERT, Recovery Auditors or *UPICs* request that a provider submit psychotherapy notes defined in 45 CFR §164.501. The refusal of a provider to submit such information shall not result in the automatic denial of a claim.

If the medical documentation includes any of the information included in the definition of psychotherapy notes in §164.501, as stated above, the provider is responsible for extracting information required to support that the claim is for reasonable and necessary services. MACs, Recovery Auditors, CERT or *UPICs* shall review the claim using the supporting documentation submitted by the provider. If the provider does not submit information sufficient to demonstrate that services were medically necessary, the claim shall be denied. Beneficiaries cannot be held liable for these denials unless they received proper liability notification before services were rendered, as detailed in CMS Pub. IOM, 100-04 chapter 30, §30.1.

3.3.2.8 - MAC Articles

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

This section applies to MACs.

A. General

The MACs have the discretion to publish articles communicating certain information to providers, such as any newly developed educational materials, coding instructions or clarification of existing medical review related billing or claims policy. The MACs are required to enter articles that address LCDs, coding or medical review-related billing and claims considerations into the Medicare Coverage Database (MCD).

For the purposes of this manual, the term "publish" will be used to describe any form of dissemination including posting on a Web site, distributing at a seminar, e-mailing, or printing in a hardcopy bulletin. The MAC Medical Review Departments are responsible for the development of articles associated with new or revised LCDs and for entering those articles into the Medicare Coverage Database. Other widespread educational articles shall not be charged to MR.

The MAC medical review departments shall send articles to the appropriate department within the MAC for publishing. All newly created articles shall be posted on the MAC's Web site where duplicate copies can be obtained by providers/suppliers.

When NCDs or other coverage instructions issued by the CMS include specific conditions or parameters for covered services, the MACs have the discretion to develop and publish a list of covered codes associated with the coverage provision. MACs have the discretion to automate denials for codes not included on the list without the development of a LCD if the NCD indicates or states that no other condition or parameters will be covered.

MACs also have the discretion to:

- Publish definitions of procedure codes, lists of items that may be billed under a particular code, or minimum requirements that providers must meet in order to bill using a certain code.

- Publish a product classification list that instructs providers about which specific products meet the definitional requirements of a particular HCPCS code. Developing or revising an LCD for this article is unnecessary.

- Explain which off-labeled uses of the Food and Drug Administration (FDA) approved drugs are considered reasonable and necessary within the diagnosis codes that reflect such uses.

- Explain the benefit category decisions and publish a list of drugs/biologicals that are considered usually self-administered. MACs should enter their self- administered medication exclusion list into the Medicare Coverage Database. This database can be accessed at www.cms.gov/mcd.

- MACs have the discretion to explain which HCPCS code or group of codes properly describes a particular service.

- MACs have the discretion to publish State non-physician licensure information that governs

services billed by the physician under the "incident to" provision.

The MACs shall ensure that articles do not conflict with NCDs, LCDs, policy, or coverage provisions in interpretive manuals. Although a comment and notice process is not required, MACs are encouraged to consult with stakeholders in the provider community when developing articles. MACs shall monitor comments about articles from clinician providers and respond to their concerns, as needed, by issuing revised or clarifying articles.

NOTE: Nothing in this section precludes the MACs or *UPICs* from making individual claim determinations, even in the absence of an article or LCD.

3.3.3 - Reviewing Claims in the Absence of Policies and Guidelines

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

The MACs, CERT, Recovery Auditors, and *UPICs* have the discretion to review claims, in the absence of polices, whether a NCD, coverage provision in an interpretive Medicare manual, or LCD exists for that service. When making individual claim determinations, they shall determine that the service in question is covered based on whether the service meets all of the conditions listed in section 3.6.2.1.

3.4.1.3 - Diagnosis Code Requirements

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

This section applies to MACs and *UPICs*, as indicated.

ICD-10-CM is used for diagnoses on inpatient discharges and for other services provided on and after the implementation of ICD-10-CM. ICD-9-CM is used for discharges and other services before the implementation of ICD-10-CM.

Section 1833(e) of the Act states that no payment should 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….” MACs and *UPICs* should require submission of information, in accordance with the requirements below, that they deem necessary to make a claim determination and 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 a LCD.

A. Claims Submitted by Physicians or Certain Non-Physician Practitioners Must Contain Diagnosis Codes.

Section 1842 (p) (1) of the Act states that for each claim submitted by physicians or certain non-physician practitioners (defined in 1842(b) (18) (C) of the Act) “shall include the appropriate diagnosis code (or codes)….” For claims submitted with invalid, truncated, or missing diagnosis codes, MACs and *UPICs* shall classify the claim as rejected as unprocessable within the MCS. See the Claims Processing Manuals IOM Pub.100-04.

B. Claims Submitted by All Other Provider Types Must Contain Diagnosis Codes if required by a LCD

During a service-specific review to address potential abuse or overutilization, MACs and *UPICs* should require that diagnosis codes be submitted with each claim for the targeted service. The

diagnosis information is used to determine if the services are covered and correctly coded. MACs and *UPICs* should require that ICD diagnosis codes be submitted by all non-physician billers with every claim for a targeted service only if such a requirement appears in a LCD for that service. This outreach shall occur via Web site, bulletin articles, etc.

For provider-specific reviews, MACs and *UPICs* have the discretion to require submission of diagnosis codes to support that the reasonable and necessary criteria has been met on all claims submitted by individual non-physician providers who have been targeted because of unusual billing practices, fraud referrals, etc., even if no LCD exists requiring such codes. For claims submitted with invalid, truncated, or missing diagnosis codes, reviewers shall classify the claim as unable to be processed, and return the claim to the provider (RTP). See the Claims Processing Manual IOM Pub.100-04.

C. 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 and 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 panel codes, contractors may review these claims. Should contractors determine the need to develop a LCD for laboratory panel codes the MAC shall develop these policies at the panel code level. In some instances of perceived abuse of the panel codes, the contractors may review the panel and deny component tests on a case-by-case basis or evaluate the need for the component level test.

3.5 - Postpayment Medical Record Review of Claims

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

The MACs shall initiate targeted provider-specific or service-specific postpayment medical record review only when there is the likelihood of a sustained or high level of payment error. RACs, *UPICs*, and SMRC shall perform postpay review of claims as outlined in their SOW.

3.5.1 - Re-opening Claims

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

This section applies to MACs, CERT, RACs, SMRC and *UPICs*, as indicated.

The MACs, CERT, RACs, SMRC, and *UPICs* shall adhere to the rules found in CFR 405.980 through 986 when conducting automated or postpayment medical record reviews. High error rate and/or potential overutilization, identified by data analysis, are reasons to perform postpayment review and represent sufficient cause to reopen claims in accordance with 42 CFR 405.986. See Pub. 100-04, chapter 34 for more information on good cause for reopening.

3.5.2 - Case Selection

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

This section applies to MACs, CERT, SMRC, and *UPICs*, as indicated.

Case review and development provisions:

The MACs and the SMRC shall not perform postpayment review of unassigned claims. A claim

submitted for a service or supply by a provider who has not accepted the Medicare fee schedule is an unassigned claim.

- The MACs, SMRC, and *UPICs* have the discretion to select cases for postpayment review on a claim-by-claim basis or use statistical sampling for overpayment estimation.

- When MACs, SMRC, and *UPICs* conduct claim-by-claim postpayment review, they shall only collect or refund the actual overpayment or underpayment amount.

- When MACs, SMRC, and *UPICs* conduct statistical sampling for overpayment estimation as specified in PIM chapter 8, they shall extrapolate the sampling results to the known universe of similar claims when calculating the projected overpayment or underpayment amount.

- The MACs, RACs, SMRC, and *UPICs* have the discretion to conduct the postpayment review onsite at the provider or supplier's location.

- MAC staff shall review their provider tracking system, using RAC Data Warehouse (RACDW) data, and consult with the *UPICs* to ensure non- duplication during the process of selecting providers for postpayment review.

- To prevent duplicate claim reviews, the MACs, SMRC, and RACs shall use the RACDW to identify, and exclude from review, claims that were previously reviewed, or that are under current review, by another contractor.

- CERT shall duplicate another contractor's review, when appropriate, if those claims are chosen as part of a statistically valid random sample to measure the improper payment rate.

- This instruction does not prevent the *UPICs* from reviewing a claim that has been reviewed by another contractor in order to support their case development or other administrative action.

- When the MACs, CERT, RACs, SMRC and *UPICs* choose to send the provider an ADR for a postpayment review, they shall do so in accordance with PIM chapter 3, §3.2.3.2. The contractors may grant an extension of the submission timeframes at their discretion or in accordance with their SOWs.

- The MACs, CERT, RACs, SMRC and *UPICs* make coverage, coding, and/or other determinations when re-adjudicating claims.

- The MACs, CERT, RACs, SMRC and *UPICs* shall document all incorrectly paid, denied, or under-coded (e.g., billed using a procedure/supply or other code that is lower than what is supported by medical documentation) items or services.

- Services newly denied as a result of re-adjudication shall be reported as positive values.

- Services that were denied, but are reinstated as a result of re-adjudication shall be reported as negative values.

- The MACs, CERT, RACs, SMRC and *UPICs* shall document the rationale for denial and include the basis for revisions in each case (important for provider appeals). MACs, CERT, and *UPICs* should include copies of the NCD, coverage provisions from interpretive manuals, or LCD and any applicable references needed to support individual case determinations. RACs and

the SMRC shall include detailed rationale as outlined in their SOWs.

- The MACs have the discretion to deny payment without the review of the claim with a medically unlikely service edit.

3.6 - Determinations Made During Review

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

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

A. General

The MACs, CERT, Recovery Auditors, and *UPICs* shall be able to differentiate the type of determination made, ensuring that limitation of liability determinations are appropriate.

When the MAC determines, through prepayment data analysis or postpayment review, that an inappropriate claim has been submitted; or the Recovery Auditor determines, in post-payment review, that an improper payment has been made, the MAC and Recovery Auditor shall verify that the error represents an unacceptable practice and not just an explainable aberrancy. Some legitimate reasons for anomalous data include:

- The provider may be associated with a medical school, research center, or may be a highly specialized facility, for instance, the facility may be a Medicare- *dependent* hospital or CAH, which might skew the type of claims submitted; or

- The community in which the provider practices may have special characteristics such as socio-economic level or a concentration of a specific age group that leads to an apparent aberrancy in the use of certain services.

The MACs, CERT, Recovery Auditors, and *UPICs* have the discretion to make other determinations during the review of a claim to avoid or identify improper payments for such things as duplicate claims, etc. Other examples are listed below:

Example 1: A Medicare policy states that when three (3) procedures are performed during the same operative session, Medicare pays 100 percent for the
first, 50 percent for the second and 25 percent for the third. A claim is identified where all three (3) procedures were paid at 100 percent.

Example 2: A claim was paid using the fee schedule from the prior year.

Example 3: A Medicare payment policy states that in order to pay for a capped rental item, consideration shall be given to whether the item was in “continuous use” by the beneficiary for a specified time period. A claim is found to have been paid out of compliance with this policy provision.

If, at any time, the medical review detects potential fraud, MACs, CERT, and Recovery Auditors, shall refer the issue to the appropriate *UPIC*.

3.6.1 - Determining Overpayments and Underpayments

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

This section applies to MACs, and *UPICs*. It does not apply to CERT or Recovery Auditors.

A. General

The results of the re-adjudication are used to determine the overpayment or underpayment amount for each claim. Re-adjudicating claims may not result in a payment correction. Where statistical sampling for overpayment estimation is used, refer to instructions in the PIM chapter 8, §8.4 and to Exhibits 9, 10, 11 and 12 for projection methodologies based on FFS claims. For claims paid under PPS rules, MACs and *UPICs* shall develop projection methodologies in conjunction with their statisticians that are consistent with the requirements found in PIM chapter 8, §8.4. MACs and *UPICs* shall net out the dollar amount of services underpaid during the cost accounting period, meaning that amounts owed to providers are balanced against amounts owed from providers.

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

- According to the provisions of §1879 of the Act, the provider or supplier is liable for the overpayment of initially paid claims that were later denied on re- adjudication if :

(1) The basis for denial is by reason of §1862(a) (l) or (9) of the Act;

(2) The provider or supplier knew or could reasonably have been expected to know that the items or services were excluded from coverage, and

- For denials of non-assigned claims make a§1842(l) determination on denials for §1862(a)(1)

- The provider or supplier was not without fault for the overpayment as defined in §1870 of the Act.

For appeal purposes, overpayment estimations applicable under §1879 of the Act will be identified separately from denials in which §1879 of the Act does not apply. Where both types of denials occur in the sample, MACs and *UPICs* calculate and document separate under/overpayments for each type of denial. For recovery purposes, however, both denial results are combined.

3.6.2 - Verifying Errors

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

This section applies to MACs, CERT, and *UPICs*, as indicated.

Understanding the characteristics of the service area of the provider is a key element of claim data analysis. The areas selected for review by the contractor (e.g., providers, services) must be deemed high priority and contractors must be able to document the rationale for selection.

3.6.2.1 - Coverage Determinations

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

The MACs, CERT, Recovery Auditors, and *UPICs* shall deny an item or service if it does not meet any of the conditions listed below:

- The item or service does not fall into a Medicare benefit category.
- The item or service is statutorily excluded on grounds other than §1862(a) (1) (A) of the Act.
- The item or service is not reasonable and necessary under §1862(a) (1) (A) of the Act.
- The item or service does not meet other Medicare program requirements for payment.

3.6.2.2 - Reasonable and Necessary Criteria

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

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

CMS issues national coverage determinations (NCDs) that specify whether certain items, services, procedures or technologies are reasonable and necessary under §1862(a) (1) (A) of the Act. In the absence of an NCD, Medicare contractors are responsible for determining whether services are reasonable and necessary. If no local coverage determination (LCD) exists for a particular item or service, the MACs, CERT, Recovery Auditors, and *UPICs* shall consider an item or service to be reasonable and necessary if the item or service meets the following criteria:

- It is safe and effective;
- It is not experimental or investigational; and
- It is appropriate, including the duration and frequency in terms of whether the service or item is:

o Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the beneficiary's condition or to improve the function of a malformed body member;

o Furnished in a setting appropriate to the beneficiary's medical needs and condition;

o Ordered and furnished by qualified personnel; and,

o One that meets, but does not exceed, the beneficiary's medical need.

There are several exceptions to the requirement that a service be reasonable and necessary for diagnosis or treatment of illness or injury in order to be considered for payment. The exceptions appear in the full text of §1862(a) (l) (A) of the Act. See also PIM chapters 13, §5.1 and 7.1.

3.6.2.3 - Limitation of Liability Determinations

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

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

Section 1879(a)-(g) of the Act limits the financial liability of beneficiaries, providers, and suppliers by permitting Medicare payments, or requiring refunds, for certain services and items for which Medicare payment would otherwise be denied. The purpose of this provision is to protect beneficiaries from liability in certain cases of denied services. The limitation of liability provisions apply only to claims for services not statutorily excluded, that are denied for the

following reasons:

- The service or item did not meet the reasonable and necessary criteria;

- The beneficiary or provider did not know, or could not have been reasonably expected to know that the service or item would not be covered; and

- The beneficiary receives certain screening tests and preventive services in excess of the guidelines.

(See IOM Pub. 100-04, chapter30, §20 for more information).

The MACs, CERT, and *UPICs* shall first examine benefit categories and statutory exclusions to determine if a service or item is covered. Recovery Auditors shall examine categories and exclusions as outlined in their SOW. If the item or service meets the requirements of the appropriate benefit category and is not excluded by statute, the next consideration is whether the service was reasonable and necessary. When a claim is denied, in full or in part, because an item or service is not reasonable and necessary, MACs, CERT, Recovery Auditors, and *UPICs* shall make and document determinations as appropriate to §§1879, 1870, and 1842(l) of the Act. Because the determinations can be appealed, it is important that the rationale for the determination be documented initially and at each level of appeal.

Limitations of liability provisions do not apply if there is a statutory exclusion, even if the service meets the reasonable and necessary criteria.

3.6.2.4 - Coding Determinations

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

This section applies to MACs, CERT, SMRC, Recovery Auditors, and *UPICs*, as indicated.

ICD-10-CM is used for diagnoses on inpatient discharges and for other services provided on and after the implementation of ICD-10-CM. ICD-9-CM is used for discharges and other services before that date.

The MACs, CERT, SMRC, Recovery Auditors, and *UPICs* shall determine that an item/service is correctly coded when it meets all the coding guidelines listed in the Current Procedural Terminology-4 (CPT-4), Coding Clinic for ICD, Coding Clinic for HCPCS, and any coding requirements listed in CMS manuals or MAC articles.

In certain situations, it is appropriate for contractors to up code or down code a claim (or items or services on a claim) and adjust the payment. When the medical record supports a higher or lower level code, the MACs, SMRC, CERT, *UPICs* and Recovery Auditors shall not deny the entire claim but instead shall adjust the code and adjust the payment.

The MACs, SMRC, CERT, *UPICs* and Recovery Auditors shall up code or down code when it is possible to pay for the item or service actually provided without making a reasonable and necessary determination or if otherwise specified in applicable CMS medical review instructions.

The MACs, SMRC, CERT, *UPICs* and Recovery Auditors shall not substitute the payment amount of one item or service for a different item or service based on a reasonable and necessary determination.

Example situations where it is appropriate to up code or down code a claim are:

1. CBC with diff was ordered and billed but CBC without diff was provided;

2. X-ray with contrast was ordered and billed but X-ray without contrast was provided;

3. E&M level 3 was billed but the medical record supports level 2 (or other level);

4. PPS (DRG/RUG/HHRG) code was billed but the medical records supports a different code; and

5. Quantity of diabetic test strips exceeds limits; for example, quantity was provided for insulin treated but the patient was not insulin treated.

3.6.2.5 - Denial Types

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

This section applies to MACs, CERT, RACs, and *UPICs*, as indicated.

A. Distinguishing Between Benefit Category, Statutory Exclusion and Reasonable and Necessary Denials

The MACs, CERT, RACs, and *UPICs* shall be cognizant that the denial type may affect the financial liability of beneficiaries. They shall ensure that benefit category denials take precedence over statutory exclusion and reasonable and necessary denials. They shall ensure that statutory exclusion denials take precedence over reasonable and necessary denials. MACs, CERT, and *UPICs* shall use the guidelines listed below in selecting the appropriate denial reason. RACs shall follow denial reason guidance outlined in their SOW.

- If additional documentation was requested from the provider or other entity for any MR reason (benefit category, statutory exclusion, reasonable/necessary, or coding), and the information is not received within 45 calendar days or a reasonable time thereafter, the MACS, CERT, and *UPICs* shall issue a reasonable and necessary denial, in full or in part.

- If additional documentation was requested because compliance with a benefit category requirement is questioned and the documentation received fails to support compliance with the benefit category, the MACs, CERT, and *UPICs* shall issue a benefit category denial.

- If additional documentation was requested because compliance with a benefit category requirement is questioned and the received documentation shows evidence that the benefit category requirement is present but is defective, the MACs, and *UPICs* shall issue a reasonable and necessary denial.

EXAMPLE 1: A MAC is conducting a review of partial hospitalization (PH) claims from a

provider who has a pattern of failing to comply with the benefit category requirement that there be a signed certification in the medical record. In the first medical record, the MAC finds that there is no signed certification present in the medical record. The MAC shall 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 MAC determines that a signed certification is present in the medical record, but the documentation does not support the physician's certification, the services shall be denied under §1862(a) (1) (A) of the Act (a reasonable and necessary denial) because the certification is present but defective.

Example 2: The MAC performs a medical record review on a surgical procedure claim and determines that the procedure was cosmetic in nature 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.

The MACs, CERT, RACs, and *UPICs* shall deny payment on claims either partially (e.g., by down coding or denying one line item on a multi-line claim) or in full, and provide the specific reason for the denial whenever there is evidence that a service:

- Does not meet the Benefit Category requirements described in Title XVIII of the Act, NCD, or coverage provision in an interpretive manual;

- Is statutorily excluded by other than §1862(a)(1) of the Act;

- Is not reasonable and necessary as defined under §1862(a) (1) of the Act. MACs, CERT, RACs, and *UPICs* shall use this denial reason for all non-responses to documentation requests;

- Was not billed in compliance with the national and local coding, payment or billing requirements; and/or

- Was not delivered or provided to the beneficiary, or not provided as billed.

The denial explanation needs to be more specific than merely repeating one of the above bullets. The general exception to the need for a full denial explanation is in the event of a clerical error, for example, the billing entity transposes two digits in the Medicare beneficiary identifier on a claim. The claim is quickly returned, usually electronically, to the provider for correction. In the case of dual-eligible beneficiaries where there is a State-specific policy, see CMS IOM Pub. 100-04, chapter 30, §60.5.A for a detailed explanation of handling administrative denials.

3.6.3 - Beneficiary Notification

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

This section applies to MACs, CERT, RACs, and *UPICs*, as indicated.

A. General

If a claim is denied through prepayment or postpayment review, the MAC shall notify the beneficiary consistent with the requirements in PIM chapter 3, §3.6.2.3. The MAC shall include limitation of liability and appeals information. Notification can occur via Medicare Summary Notice (MSN). The CERT, RACs, and *UPICs* are not required to issue beneficiary notices for claims they deny. Instead, CERT, RACs, and *UPICs* shall communicate sufficient information to the MAC to allow the MAC to develop an appropriate beneficiary notice.

The MACs are required to give notice to Medicare beneficiaries when claims are denied in part or in whole based on application of a LCD. All denials that result from LCDs shall provide the MSN message 15.19 in addition to the current applicable message. Message 15.19 states (IOM Pub. 100-04, chapter 21):

“A local coverage determination (LCD) was used when we made this decision. A LCD provides a guide to assist in determining whether a particular item or service is covered by Medicare. A copy of this policy is available from your local intermediary, carrier or (Medicare Administrative Contractor) by calling the number in the customer service information box on page one. You can compare the facts in your case to the guidelines set out in the LCD to see whether additional information from your physician would change our decision.”

The MACs shall make these messages available in Spanish where appropriate. The 15.19 portion of the MSN message states:

Una Determinación de Cobertura Local (LCD, por sus siglas en inglés) fue utilizada cuando se tomó esta decisión. La LCD es una guía que ayuda a determinar si un artículo o servicio en particular está cubierto por Medicare. Una copia de esta póliza está disponible en su intermediario, local o en su empresa de seguros Medicare, o en su Contratista Administrative de Medicare, al llamar al número que aparece en la información de Servicios al Cliente en la página uno. Usted puede comparar los datos de su caso con las reglas establecidas en la LCD para ver si obteniendo información adicional de su médico pudiera cambiar nuestra decisión.

The MACs shall use the above message in every instance of a prepayment denial where a LCD was used in reviewing the claim. Use this message, and message 15.20 (now for FISS MACs, and when 15.20 is fully implemented for contractors on the MCS/VMS systems) on both full and partial denials, whether the denial was made following automated, non-medical review, or medical record review. MACs shall not use this message on denials not involving LCDs. For claims reviewed on a postpayment basis, include the language exactly as contained in the MSN message above if sending the beneficiary a new MSN. If sending a letter, include the language exactly as contained in the MSN message above. Message 15.20 currently states:

“The following policies [insert LCD ID# and NCD#] were used when we made this decision.”(Pub.100-04, chapter 21).

The MACs shall continue to use 15.19 in conjunction with the MSN message 15.20, where 15.19 is applicable. MACs should, at their discretion, combine these messages if necessary, but 15.19 shall not be deleted.

In the case where the results of claims sampling are extrapolated to the universe, only those beneficiaries in the sample need to be notified. In RAC cases, the RAC and MAC Joint Operating Agreement (JOA) shall specify what information the RAC will supply to allow the MAC to notify the beneficiary when re-adjudication results in a change to the initial determination.

3.6.4 - Notifying the Provider

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

This section applies to, MACs, RACs, and *UPICs*, as indicated.

A. General

At the conclusion of postpayment review, the MACs shall send a Review Results Letter to the provider even if no overpayment determination is made. If the MACs choose to send a Review Results Letter separately from the demand letter they shall do so within the timeframes listed in PIM chapter 3, §3.3.1.1F. Likewise, the RACs shall issue a Review Results Letter for all audits as outlined in their SOW requirements.

UPICs shall comply with the requirements listed below when issuing Review Results Letters. Each Review Results Letter shall include:

- Identification of the provider or supplier—name, address, and NPI;

- Reason for conducting the review or good cause for reopening;

- A narrative description of the overpayment situation that states the specific issues involved in the overpayment as well as any recommended corrective actions;

- The review determination for each claim in the sample, including a specific explanation of why any services were determined to be non-covered, or incorrectly coded and if others were payable;

- A list of all individual claims that includes the actual non-covered amount, the reason for non-coverage, the denied amounts, under/overpayment amounts, the §1879 and §1870 of the Act determinations made for each specific claim, along with the amounts that will and will not be recovered from the provider or supplier;

- Any information required by PIM chapter 8, §8.4 for statistical sampling for overpayment estimation reviews;

- Total underpayment amounts;

- Total overpayment amounts that the provider or supplier is responsible for;

- Total overpayment amounts the provider or supplier is not responsible for because the provider or supplier was found to be without fault;

- MACs shall include an explanation that subsequent adjustments may be made at cost settlement to reflect final settled costs;

- 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 (not applicable to RACs or *UPICs*);

- The provider's or supplier's right to request an extended repayment schedule (not applicable to RACs or *UPICs*);

- The MACs and *UPICs* shall include limitation of liability and appeals information in the provider notices;

- The MACs shall include appeals information in the provider notices;

- The MACs shall include the provider or supplier financial rebuttal rights under PIM chapter 3, §3.6.5; and,

- For MAC Review Results Letter only, a description of any additional corrective actions or follow-up activity the MAC is planning (i.e., prepayment review, re- review in 6 months).

If a claim is denied through prepayment review, the MACs and *UPICs* are encouraged to issue a notification letter to the provider but may use a remittance notice to meet this requirement. However, if a claim is denied through postpayment review, the MAC and RAC shall notify the provider by issuing a notification letter to meet this requirement. The *UPIC* shall use discretion on whether to issue a notification letter.

The CERT contractor is NOT required to issue provider notices for claims they deny. Instead, the CERT contractor shall communicate sufficient information to the MAC to allow the MAC to develop an appropriate provider notice.

B. MACs

The MACs need provide only high-level information to providers when informing them of a prepayment denial via a remittance advice. In other words, the shared system remittance advice messages are sufficient notices to the provider. However, for medical record review, the provider should be notified through the shared system, but the MAC shall retain more detailed information in an accessible location so that upon written or verbal request from the provider, the MAC can explain the specific reason the claim was denied as incorrectly coded or otherwise inappropriate.

C. RACs

For overpayments detected through medical record review, the RAC shall send a review results letter as indicated in the RAC SOW. In addition, the RAC shall communicate sufficient information to the MAC so that the MAC can send a remittance advice to the provider and collect the overpayment.

For underpayments, the RAC shall notify the provider as indicated in the RAC SOW. In addition, the RAC shall communicate sufficient information to the MAC so that the MAC can send a remittance advice to the provider and pay back the underpayment.

D. *UPICs*

For overpayments detected through medical record review, and after coordination between the *UPIC* and OIG, the *UPIC* shall send a review results letter (the MAC sends the demand letter). In addition, the *UPIC* shall communicate sufficient information to the MAC so that the MAC can send a demand letter to the provider and collect the overpayment. The *UPIC* shall use discretion on whether to send the review results letter.

E. Indicate in the Denial Notice Whether Records Were Reviewed

For claims where the MAC or *UPIC* had sent an ADR letter and no timely response was received, they shall issue a denial and indicate in the provider denial notice, that the denial was made without reviewing the documentation because the requested documentation was not received or was not received within the allowable time frame (§1862(a) (1) of the Act). This information will be useful to the provider in deciding whether to appeal the decision. When

denying the claims, contractors shall use Group Code: CO - Contractual Obligation and Claim Adjustment Reason Code (CARC) 50 - these are non-covered services because this is not deemed a “medical necessity” by the payer and Remittance Advice Remark Code (RARC) M127 - Missing patient medical record for this service.

For claims where the reviewer makes a denial following medical record review, the reviewer has the discretion to indicate in the denial notice, using Group Code: CO - Contractual Obligation and Claim Adjustment Reason Code (CARC) 50 - these are non- covered services because this is not deemed a “medical necessity” by the payer that the denial was made after review of submitted documentation. This includes those claims where the provider submits documentation along with the claim and the reviewer selects that claim for review.

3.6.5 - Provider Financial Rebuttal of Findings

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

This section applies to the MACs. It does not apply to Recovery Auditors, CERT, and *UPICs*.

A. General

Providers or suppliers have the right to submit a financial rebuttal statement in accordance with 42 CFR 405.370-375 following receipt of the review results letter and prior to recoupment of the overpayment. The rebuttal statement and any accompanying evidence must be submitted within 15 calendar days from the date of the results letter unless the MAC staff find cause to extend or shorten the time frame.

B. Review of Financial Rebuttal Statement(s)

Within 15 calendar days of receipt of a financial rebuttal, MAC staff shall consider the statement and any evidence submitted to reach a determination regarding whether the facts justify the recoupment. However, the MAC shall not delay recovery of any overpayment beyond the date indicated in the review results 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)). The MAC shall provide a copy of the rebuttal request and a copy of the MAC’s response on the rebuttal outcome to the *UPICs*.

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 for overpayment estimation is based on the interim payment rate in effect at the time of the review.

3.6.6 - Review Determination Documentation Requirements

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

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

For each claim denied, in full or in part, the MACs, CERT, and *UPICs* shall carefully document the basis for the denial in the internal claim record. If there are several reasons for denial they shall document each reason in the internal claim record. In addition, the internal claim record should document the date and content of the provider notice of review (§ 3.2.2), additional

documentation requests (§3.2.3), and third party documentation requests and response (§3.2.3.3).

In verifying an overpayment, MACs, CERT, Recovery Auditors, and *UPICs* shall 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.

3.7.1 - Progressive Corrective Action (PCA)

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

This section applies to MACs.

The MACs shall ensure that actions imposed upon Medicare providers or suppliers for failure to meet Medicare rules, regulations and other requirements are appropriate given the level of non-compliance.

When an error has been validated through MR, the corrective action imposed by the MACs should match the severity of the error. PCA is a means of evaluating the relative risk of the error and assigning appropriate corrective actions. The principles of PCA are:

- It is data-driven. Errors are validated by prepayment and postpayment claims review. (See below).

- Hypotheses and edits are tested prior to implementation to determine facility, utility, and return on investment.

- Workloads are targeted, specific, and prioritized.

- Money is collected when errors are validated.

- Referrals for potential fraud are made when necessary.

- Provider feedback and education are mandatory.

- Medical review resources should be used efficiently.

For each provider data identifies as being at risk, the potential error is validated with prepayment or postpayment review of generally 20-40 potentially erroneous claims. Payments are either denied or recouped. Any underpayments by Medicare will be netted out during the financial reconciliation process. Corrective actions are then implemented based on whether the error represents a minor, moderate, or major concern.

For potentially risky services, errors are validated by prepayment and postpayment review of generally up to 100 potential problem claims for that service from a representative sample of providers. Service-specific errors may require more widespread education for providers and may require the implementation of service-specific prepayment edits.

An example of a minor concern would be a provider with a low error rate and no pattern of errors who has made a relatively minor error with low financial impact. Education and collection of the overpayment may be sufficient corrective actions.

For moderate concerns, where a provider with a low error rate has made an error with substantial

financial impact, some level of prepayment review should be considered. The prepayment review should be tracked and adjusted or eliminated according to the provider's response.

A major concern would be a provider with a high error rate who has made a high-dollar error with no mitigating circumstances, indicating the need for stringent administrative action. A high level prepayment review should be considered along with possible payment suspension and referral to the *UPICs*.

3.7.3 - Evaluating the Effectiveness of Corrective Actions

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

This section applies to MACs.

The MACs shall evaluate the effectiveness of their corrective actions on targeted providers or problem areas at least every three (3) months until there is evidence that the poor practice has been corrected. MACs shall establish a method to determine the disposition of educational referrals made to POE to ensure coordination of efforts and resolution of identified problems. MACs have the discretion to use the PTS to perform this function, but are not mandated to do so. MACs shall use the PTS to coordinate contacts with providers regarding MR activities. MACs shall also coordinate this information with the *UPICs* to ensure contacts are not in conflict with fraud related activities.

3.7.3.2 - Evaluating Effectiveness of Established Automated Edits

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

This section applies to MACs.

MACs shall consider the following factors when looking at edit effectiveness for established automated edits:

- Time and staffing needs for review and appeal reviews. MACs shall implement mechanisms (e.g., manual logs, automated tracking systems) to allow the appeals unit to communicate to the MR unit information such as when denial categories are causing the greatest impact on appeals, the outcome of the appeal, and

- MACs shall maintain and make available to the appropriate CMS staff documentation demonstrating that they consider appeals in their edit evaluation process; and specificity of edits in relation to identified problem(s).

The MACs should note that even an automated edit that results in no denials may be effective as long as the presence of the edit is not preventing the installation of other automated edits. The MAC shall provide the claims data necessary to the *UPIC* to evaluate the effectiveness of edits implemented at *UPIC* request. The MACs shall provide this report on a monthly basis by the 15th business day of each month. This requirement could also be met by the *UPICs* retrieving claim data necessary directly from the EDC if available.

A. Edit Effectiveness for all Other Edits

The MACs shall consider the following factors when looking at edit effectiveness for all other edits:

- Time and staffing needs for review and appeal reviews. MACs shall implement mechanisms (e.g., manual logs, automated tracking systems) to allow the appeals unit to communicate to the MAC MR unit and the *UPIC* just specific to *UPIC* edits information such as which denial categories are causing the greatest impact on appeals, and the outcome of the appeal. MACs shall maintain and make available to CMS documentation demonstrating that appeal outcomes are considered in their edit evaluation process;

- Specificity of edits in relation to identified problem(s);

- Demonstrated change in provider behavior, i.e., the MAC can show a 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 relative priorities or competing edits in terms of the number of claims/days/charges.

The MACs shall test each edit before implementation to verify that the edit accomplishes the objective of efficiently selecting claims for review and to determine the edit's impact on workload.

3.7.3.3 - Evaluation of Postpayment Review Effectiveness

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

This section applies to MACs.

The MACs shall determine if any other corrective actions are necessary such as:

- Uncovering potential fraud in the course of MR postpayment review activities. The MR unit shall refer these cases to the *UPIC*. If it is believed that the overpayment resulted from potential fraud, a refund may not be requested from the provider until the potential fraud issue is resolved.

- Initiating provider or supplier specific edits to focus prepayment view on the problem provider or supplier or group of providers or suppliers, if appropriate;

- Working with the CMS Central Office Division of Benefit Integrity Management Operations (DBIMO) Fraud and Abuse Suspensions and Sanctions (FASS) Team to suspend payment to the provider or group of providers;

- Referring provider certification issues to the State survey agency through CMS staff;

- Referring quality issues involving inpatient hospital services to the RO and QIO; and

- Coordinating with the QIO and MAC on interrelated billing problems

The MACs periodically perform a follow-up analysis of the provider(s) or supplier(s) 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 or supplier after the three (3) month time period. The MACs shall continue to monitor the provider(s) or supplier(s) until there is a referral to the *UPICs* for potential fraud, evidence that the utilization or billing problem

is corrected, or data analysis indicating resources would be better utilized elsewhere.

3.8 - Administrative Relief from MR During a Disaster

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

This section applies to MACs and Recovery Auditors. *UPICs* refer to the PIM chapter 4.

A. General

When a disaster occurs, whether natural or man-made, MACs and Recovery Auditors shall anticipate both an increased demand for emergency and other health care services, and a corresponding disruption to normal health care delivery systems and networks. In disaster situations, MACs should do whatever they can to ensure that all Medicare beneficiaries have access to the emergency or urgent care they need. MACs are encouraged to let providers know (via Web site, responses to provider calls, etc.) that the provider's first responsibility, as in any emergency, is to provide the needed emergency or urgent service or treatment. The MACs should assure providers they will work with providers to ensure that they receive payment for all covered services. The administrative flexibility available to MACs and Recovery Auditors is discussed below. These actions will prevent most inappropriate denials and subsequent appeals.

B. Definition of Disaster

A disaster is defined as any natural or man-made catastrophe (such as hurricane, tornado, earthquake, volcanic eruption, mudslide, snowstorm, tsunami, terrorist attack, bombing, fire, flood, or explosion) which causes damage of sufficient severity and magnitude to partially or completely destroy medical records and associated documentation that could be requested by the MACs and Recovery Auditors in the course of a Medicare audit, interrupt normal mail service (including US Postal delivery, overnight parcel delivery services, etc.), and/or otherwise significantly limit the provider's daily operations.

A disaster may be widespread and impact multiple structures (e.g., a regional flood) or isolated and impact a single site only (e.g., water main failure). The fact that a provider is located in a presidentially declared disaster area under the power of the Stafford Act is not sufficient in itself to justify administrative relief, as not all structures in the disaster area may have been subject to the same amount of damage. Damage must be of sufficient severity and extent to compromise retrieval of medical documentation.

C. Basis for Providing Administrative Relief

In the event of a disaster, MACs and Recovery Auditors shall grant temporary administrative relief to any affected providers for up to 6 months (or longer with good cause). Administrative relief is to be granted to providers on a case-by-case basis in accordance with the following guidelines:

- The MACs and Recovery Auditors shall make every effort to be responsive to providers who are victims of the disaster and whose medical documentation may be partially or completely destroyed.

- Providers must maintain and submit verification upon contractor request by the MAC or Recovery Auditor that (1) a disaster has occurred and (2) medical record loss resulted from this disaster to the point where administrative relief from medical review requirements is necessary

to allow the provider sufficient time to retrieve copies of, or restore damaged, medical documentation.

Verification of the disaster and the resultant damage should include but is not limited to:

(1) Copies of claims filed by the provider with his/her insurance and liability company,
(2) Copies of police reports filed to report the damage;
(3) Copies of claims submitted to FEMA for financial assistance;
(4) Copies of tax reports filed to report the losses; or
(5) Photographs of damage. MACs and Recovery Auditors shall not routinely request providers to submit verification of damage or loss of medical record documentation.

D. Types of Relief

Providers Directly Affected By Disaster

The MACs and Recovery Auditors shall stop sending ADR letters to providers who have been directly affected for at least 60 calendar days. The MACs and Recovery Auditors shall allow up to an additional six months beyond the original due date for the submission of requested records. Requests for extensions beyond this date can be granted with good cause at the discretion of the MAC or Recovery Auditor.

In the case of complete destruction of medical records where no backup records exist, MACs and Recovery Auditors shall accept an attestation that no medical records exist and consider the services covered and correctly coded. In the case of partial destruction, MACs and Recovery Auditors should instruct providers to reconstruct the records as much as possible with whatever original records can be salvaged. Providers should note on the face sheet of the completely or partially reconstructed medical record: "This record was reconstructed because of disaster."

Providers Indirectly Affected By Disaster

For providers that are indirectly affected by a disaster (e.g., an interruption of mail service caused by a grounding of US commercial air flights), MACs and Recovery Auditors shall take the following actions:

For ADRs, extend the parameter that triggers denial for non-receipt of medical records from 45 calendar days to 90 calendar days. ADRs shall reflect that the response is due in 90 calendar days rather than 45 calendar days. This action will prevent most inappropriate denials and unnecessary increases in appeals workload.

If the MAC or Recovery Auditor receives the requested documentation after a denial has been issued but within a reasonable number of days beyond the denial date, the MAC or Recovery Auditor has the discretion to reopen the claim and make a medical review determination. Many reviewers follow a standard 15 calendar days although MACs and Recovery Auditors shall make these decisions on a case-by-case basis. The MACs and Recovery Auditors shall allocate the workload, costs and savings to the appropriate MR activity.

The MACs and Recovery Auditors shall review reopened claims retroactively to the date of the disaster. The MAC's data analyses shall take into consideration the expected increase in certain services in disaster areas.

E. Impact on MAC Performance Evaluations

During performance evaluations, CMS will consider a waiver to all MAC MR requirements, as necessary, to allow MACs the flexibility to handle issues that arise in the aftermath of a disaster. Examples of such waived requirements include workload targets and any other MR administrative rules. MACs shall retain documentation of how their MR operations were affected during the disaster and make it available to Performance Evaluation Teams and other CMS Staff, upon request.

3.9.1 - Election of Status

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

The contractor shall establish a process for assessing the NOHs received to determine which cases should be selected for participation, as well as the type of participation (participant, party, or witness) to be employed. Factors to be examined should include, but not be limited to: originator of initial denial, policy implications, dollars at issue, program integrity matters, and the extent to which a particular issue is, or has been, a recurring issue at the ALJ level of appeal.

Contractors shall, for those cases in which they were the medical reviewer issuing the denial subject to appeal, have a prioritized ability to invoke party status (in lieu of other appeals support contractors). This process is further described below.

A. Election of Participation Status Prior to Receipt of a Formal NOH

The election to participate as a participant shall be made consistent with 42 CFR §405.1010 and can be done either prior to receipt of a formal NOH or after the receipt of a formal NOH.

The regulations allow CMS contractors to elect to participate as a participant before issuance and/or receipt of the formal NOH. See section of 42 CFR §405.1010(b)(1) for additional information. If the contractor elects to participate before the receipt of the NOH, it shall send written notice of its intent to the assigned ALJ or attorney adjudicator, or the designee of the Chief ALJ, if no contact assigned yet, and to all parties on the reconsideration (per the prescribed OMHA process) within 30 calendar days after notification that a request for hearing had been filed. In accordance with the regulations, a position paper or written testimony must either be submitted within 14 calendar days of an election to participate, if no hearing has been scheduled, or no later than 5 calendar days prior to the hearing, if a hearing is scheduled, unless the ALJ grants additional time to submit the position paper or written testimony. Contractors should note that there is a risk that the case may be later resolved by the ALJ, or an Attorney Adjudicator within the OMHA, without a hearing.

B. Election of Participation or Party Status Following Receipt of the Formal NOH

The election to be a participant or a party to a hearing after receipt of the formal NOH shall be made consistent with 42 CFR §405.1010(b) or 42 CFR §405.1012, respectively, and the CMS-prescribed prioritization process, described below. If through the CMS- prescribed prioritization process it is determined that the contractor may act as either the party or a participant to a hearing, elections of participation must be sent by the Contractor within 10 calendar days of receipt of the NOH at the AdQIC to all parties listed on the NOH. Submission of a position paper, written testimony, and/or evidence must be submitted no later than five calendar days before the date of the scheduled hearing. Copies of these items must also be sent to those parties listed on the NOH in accordance with 42 CFR §405.1010(c)(3)(ii) and 42 CFR §405.1012(c)(2)(ii).

C. CMS-prescribed Prioritization Process and AdQIC Portal for Providing a Response to the Formal NOH

As the AdQIC is tasked with coordinating contractor interest in participation among the related CMS contractors and/or CMS, all NOHs will be sent directly to the AdQIC from the OMHA. The AdQIC, within two (2) calendar days of receipt of the formal NOH from OMHA, will create a record in the AdQIC portal that will generate an email notification to all applicable CMS contractors (e.g., DME MAC, A/B MAC, UPIC, SMRC, and/or RAC) notifying them that a hearing has been scheduled.

Upon receipt of the formal NOH e-mail alert, all applicable CMS contractors shall log onto the AdQIC website, https://participation.q2a.com, to access the NOH information. All applicable CMS contractors shall make their elections, via the AdQIC website, within five (5) calendar days of the formal NOH e-mail sent date. To make an election, contractors must sign-in on the website (see above), and a dashboard will be available listing all appeals for the respective contractor that they may choose to participate in.

Users can also search for appeals based on the information provided in the notification email. Next, the contractors shall select the applicable NOH identifier and complete/submit the CMS Contractor Participation Form indicating for each appeal whether they would like to participate as a party, participant, or witness, and/or if they would like to call a witness if made a party to the hearing. CMS contractors that fail to sign-in to the AdQIC system and make their respective participation role selections, in the required timeframe, may be precluded from the prioritization process.

Note: Users will not be able to view the actual NOH document on the site. The web-site/dashboard will allow contractors to view all scheduled hearings for which they received an NOH.

For all NOH communications (e.g., NOHs received from OMHA, NOH email alerts) received after standard business hours (e.g., 4:00 p.m., ET) and/or during weekends or business Holidays, as defined by the respective entity, the AdQIC portal is programmed to calculate the response time beginning with the next applicable business day [e.g., if the AdQIC receives the formal NOH on a Friday at 4:00 pm, the five (5) calendar day timeframe begins on Monday (with Monday being day zero (0))].

The AdQIC portal will evaluate all submissions received and determine which entity shall have the primary opportunity to participate as a 'party,' and which entities can participate as 'participants' or 'witnesses' based on CMS' prioritization logic.

The anticipated prioritization for the role of party status is as follows:

1) Primary opportunity for the 'party' role in an ALJ hearing will be granted to the entity that conducted the initial claim denial (e.g., *UPIC*, RAC, SMRC or medical review unit within the MAC).
2) If the entity that issued the initial claim denial does not have interest in participating as a party (due to workload considerations or otherwise) the QIC will have the primary opportunity to participate as a party.
3) If no CMS contractors and/or CMS wish to invoke 'party' status in a hearing and multiple entities wish to be a participant, the primary participant shall be the entity that conducted the initial claim denial (e.g., *UPIC*, RAC, SMRC, or medical review unit within the MAC).

4) If the entity that identified/conducted the initial claim denial does not wish to be the 'primary' participant on the case, the QIC will have the next opportunity to assume this role.

The AdQIC portal will review and prioritize contractor roles in a respective ALJ hearing (i.e., which contractor shall be the 'party', 'participants,' etc.), within 2 calendar days of receipt of the completed Contractor Participation forms. The website will automatically calculate the contractor's Participation Form response due date and each contractor's role determination, and prioritize participation elections on the next calendar day after the contractor response timeframe expires. Participation/role designations will be sent via a system-generated email notification to any contractors who expressed interest in participation. The status of elections for a given NOH will be available on the AdQIC's website once determinations have been made and notifications have been sent to the applicable CMS contractors.

On rare occasion, the QIC may need to facilitate a call with the CMS and the related contractors to determine the roles and/or responsibilities on a particular hearing.

Within 10 calendar days from the initial NOH receipt date, the AdQIC will reply on behalf of all applicable CMS contractors to the NOH and OMHA with a consolidated response. The consolidated response shall include a Notice of Election form for each applicable CMS contractor for a given NOH.

In the event that OMHA issues an amended NOH, the amended NOH email will be sent from OMHA directly to the AdQIC. The AdQIC will alert all applicable CMS contractors of the amended NOH within 2 calendar days of receipt of the amended NOH email from OMHA. CMS contractor participation roles, as determined via the prioritization process in the response to the original NOH and submitted to OMHA via a Notice of Intent (NOI), shall remain intact following issuance of an amended NOH by OMHA. However, if a CMS contractor wishes to change their method of participation following the receipt of an amended NOH, then the CMS contractor shall notify/work with the AdQIC and OMHA, as applicable (e.g., if another CMS contractor was designated as the Party and the QIC was made a non-party Participant, but now the QIC wishes to serve as a Party following the receipt of an amended NOH, then the QIC must request 'leave' with the ALJ and notify the AdQIC if the request for 'leave' is approved).

D. Communications Outside of the Portal/AdQIC Process

While the AdQIC and its prioritization portal provide useful vehicles for assessing information transcribed from the notices of hearing received from OMHA and providing formal response, contractors are reminded of regulatory communications that occur outside of this process.

Contractors are reminded that the AdQIC portal and prioritization process is initiated by receipt of an NOH from OMHA. Therefore, Contractors electing status prior to receipt of an NOH shall follow the regulatory process (outlined in 42 CFR §405.1010) to alert OMHA and other parties that were sent a copy of the notice of reconsideration of their intent to participate, which occurs outside of the portal.

In accordance with section of 42 CFR §405.1010(b)(2) and (3), if a contractor elects to participate in an ALJ hearing, the contractor (not the AdQIC) shall provide written notice of its intent to participate to the parties who were sent a copy of an NOH. Failure to notify the other parties to the appeal, of the intent to participate, may result in the ALJ determining the contractor's election for a given NOH invalid. This requirement remains applicable in the event of an amended NOH, and contractors shall ensure compliance. All pertinent information (e.g. party names, mailing address) will be available in the portal for a given NOH.

Additionally, CMS contractors participating or taking party status shall provide copies of all submitted position papers, written testimony, and/or evidence to the ALJ and other appropriate parties within the time frames as set forth in 42 C.F.R. sections 405.1010, 405.1012, or 423.2010, as applicable. Failure to provide copies of submitted position papers, written testimony, and/or evidence within the required timeframe will result in the submissions not being considered by the respective ALJ. Providing copies of all submitted position papers, written testimony, and/or evidence to the appropriate parties remains applicable in the event an amended NOH is issued and contractors shall ensure compliance.

If a contractor requests ‘leave’ to the ALJ, or formally requests the ALJ to grant the contractor the right to be a secondary party to the hearing, this process occurs outside of the portal.

The ALJ sets the hearing date, time, and method by video teleconferencing (VTC), telephone, or in-person if VTC is not available or special circumstances exist. A party may object in writing to the time and place of the hearing, as soon as possible before the originally scheduled time but no later than 5 calendar days prior to the hearing, and include the reason for the objection along with a proposed alternative date and time. In addition, a party may request an in-person hearing by notifying the ALJ in writing and following the same procedures noted above for an objection to the time/place of the hearing. The ALJ may reschedule if good cause is established per 42 CFR §405.1020(f) or (g).

Medicare Program Integrity Manual

Chapter 4 – Program Integrity

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Transmittals for Chapter 4

4.14 - Provider/Supplier Contacts by the *UPIC*

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

This section applies to UPICs.

A UPIC may determine that the resolution of an investigation does not warrant administrative action and that an educational meeting with the provider/supplier is more appropriate. The UPIC shall inform the provider/supplier of the questionable or improper practices, the correct procedure to be followed, and that continuation of the improper practice may result in administrative actions. The UPIC shall document contacts and/or warnings with written reports and correspondence to the provider/supplier and place them in the investigation file in the UCM.

If the provider/supplier continues aberrant billing practices, the UPIC shall initiate the appropriate administrative actions. If the UPIC meets with a provider/supplier, the UPIC shall prepare a detailed report for the investigation file in the UCM. The report shall include the information in A, B, and C below:

A. Background of Provider/Supplier (Specialty)

The UPIC shall include a list of all enterprises in which the subject had affiliations, the states where the provider/supplier is licensed, all past complaints, and all prior educational contacts/notices.

B. Total Medicare Earnings

The UPIC shall include a report of the subject provider's/supplier's total Medicare earnings for the past 12 months.

The report shall include the following:

- Earnings for the procedures or services in question;
- Frequency of billing for these procedures/services; and
- Total number of claims submitted for these procedures/services.

C. Extent of Review Performed

The UPIC shall include in the detailed report, to be placed in the investigative file, the number and type of reviews performed, as well as the specific information outlined below:

- A report of the review process, including methodologies utilized, reason for the review, and findings;
- Any administrative actions implemented (e.g., overpayments identified); and

- Recommendation(s).

D. Report of Meeting

The UPIC shall include information pertaining to the meeting(s) conducted with the provider/supplier. This report shall include the following:

- Minutes from the meeting describing the problems and/or aberrancies discussed with the

provider/supplier and the education provided to the provider/supplier to correct those problems based on the UPIC's MR; and

- Copies of educational materials given to the provider/supplier before, during, or subsequent to the meeting.

E. Written Correspondence Regarding Non-compliance

Per the abuse of billing authority under 42 C.F.R. § 424.535(a)(8)(ii) for a pattern or practice of submitting claims that do not meet Medicare requirements and in an effort to fully inform providers of the potential administrative actions that may be imposed based on continued violations of Medicare policy, the below statement should be included in all post payment correspondence that include an error rate, and if applicable, other communications that identify non-compliant billings and inform the provider/supplier of their non-compliance with Medicare requirements.

In addition, we remind you that our regulation at 42 CFR § 424.535 authorizes us to revoke Medicare billing privileges under certain conditions. In particular, we note that per 42 CFR § 424.535(a)(8)(ii), CMS has the authority to revoke a currently enrolled provider's or supplier's Medicare billing privileges if CMS determines that the provider or supplier has a pattern or practice of submitting claims that fail to meet Medicare requirements.

4.19.2.6 - Denial of Payment to an Excluded Party

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

The *UPICs* shall not recommend payments to the AC or MAC, and ACs and MACs shall not make payment on any excluded individual or entity for items or services furnished, ordered, or prescribed in any capacity on or after the effective date of exclusion, except in the following cases:

- For inpatient hospital services or post-hospital SNF care provided to an individual admitted to a hospital or SNF before the effective date of the exclusion, make payment, if appropriate, for up to 30 days after that date.

- For home health services provided under a plan established before the effective date of exclusion, make payment, if appropriate, for 30 days after the date on the notice.

- For emergency items and services furnished, ordered, or prescribed (other than an emergency item or service furnished, ordered, or prescribed in a hospital emergency room) payment may be made to an excluded provider on or after the effective date of exclusion.

Medicare Program Integrity Manual

Chapter 5 – Items and Services Having Special DME Review Considerations

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(Rev. 10228; Issued: 07-27-20)

Transmittals for Chapter 5

5.2.8 - Refills of DMEPOS Items Provided on a Recurring Basis

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

This section applies to DME MAC and *UPICs*.

For DMEPOS products that are supplied as refills to the original order, suppliers must contact the beneficiary prior to dispensing the refill and not automatically ship on a pre-determined basis, even if authorized by the beneficiary. This shall be done to ensure that the refilled item remains reasonable and necessary, existing supplies are approaching exhaustion, and to confirm any changes/modifications to the order.

Contact with the beneficiary or designee regarding refills must take place no sooner than 14 calendar days prior to the delivery/shipping date. For delivery of refills, the supplier must deliver the DMEPOS product no sooner than 10 calendar days prior to the end of usage for the current product. This is regardless of which delivery method is utilized. DME MACs shall allow for the processing of claims for refills delivered/shipped prior to the beneficiary exhausting his/her supply.

5.3 - Certificates of Medical Necessity (CMNs) and DME Information Forms (DIFs)

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

A Certificate of Medical Necessity (CMN) or a DME Information Form (DIF) is a form required to help document the medical necessity and other coverage criteria for selected DMEPOS items. CMNs contain Sections A through D. Sections A and C are completed by the supplier and Sections B and D are completed by the physician. A DIF is completed and signed by the supplier. It does not require a narrative description of equipment and cost or a physician signature.

The following forms below have been approved by the Office of Management and Budget (OMB). For the CMS. For the CMS forms 484, 846, 847, 848, 849, 854, 10125 and 10126, the OMB# is 0938-0679.

- CMN CMS-484 – Oxygen
- CMN CMS-846 – Pneumatic Compression Devices
- CMN CMS-847 -- Osteogenesis Stimulators
- CMN CMS-848 – Transcutaneous Electrical Nerve Stimulators
- CMN CMS-849 – Seat Lift Mechanisms
- CMN CMS-854 – Section C Continuation Form
- DME Information Form CMS-10125 – External Infusion Pumps
- DME Information Form CMS-10126 – Enteral & Parenteral Nutrition

The TENS CMN is for purchases only. A TENS CMN will no longer be necessary for rentals.

For certain items or services billed to a DME MAC, the supplier must receive a signed CMN from the treating physician or a signed DIF from the supplier. For these items, a supplier must have a signed original, faxed, photocopied, or electronic CMN or DIF in their records when submitting a claim for payment to Medicare.

A signed original, faxed, photocopied, or electronic CMN or DIF must be maintained by the supplier and be available to the DME MACs, *UPICs*, SMRC, and DME RACs on request. When

hardcopy CMNs or DIFs are submitted to the DME MACs, *UPICs*, SMRC and DME RACs, the supplier must include a copy of only the front side. When CMNs are submitted electronically to the DME MAC, information from sections A and B are required.

It is in the supplier's interest to maintain a copy of what they faxed to the physician. Suppliers must maintain a copy of the completed CMN or DIF in their records. However, if the physician only faxes the front of the completed CMN then the supplier is only required to maintain the front portion of the CMN.

However, when the CMN or DIF is submitted electronically and the supplier chooses to maintain a hard copy CMN or DIF, the font may be modified as follows:

- Pitch may vary from 10 characters per inch (cpi) to 17.7 cpi;
- Line spacing must be 6 lines per inch
- Each form must have a minimum 1/4 inch margin on all four sides.

Without exception, these modified hard copy forms must contain identical questions/wording to the CMS forms, in the same sequence, with the same pagination, and identical instructions/definitions printed on the back; and CMN question sets may not be combined.

The CMN can serve as the physician's detailed written order if the narrative description in section C is sufficiently detailed. This would include quantities needed and frequency of replacement for accessories and supplies. For items requiring both a CMN and a written order prior to delivery (e.g., seat lift mechanisms) suppliers may utilize a completed and physician-signed CMN for this purpose. Otherwise, a separate order in addition to a subsequently completed and signed CMN is necessary.

The supplier may not complete the information in section B of the CMN. A supplier who knowingly and willfully completes section B of the form is subject to a civil monetary penalty up to $1,000 for each form or document so distributed. Any supplier who remains in non-compliance after repeated attempts by the contractor to get the supplier into compliance, refer to your RO (for *UPICs* refer the supplier to the primary GTL or associate GTL and SME) as a potential civil monetary penalty case.

The fee schedule amount, narrative description of the items furnished and the supplier's charge for the medical equipment or supplies being furnished must be completed on a CMN by the supplier prior to it being furnished to the physician. A supplier who knowingly and willfully fails to include this information may be subject to a civil monetary penalty up to $1,000 for each form or document so distributed. Any supplier who remains in non-compliance, after repeated attempts by the contractor to get the supplier into compliance, refer to your RO (for *UPICs*, refer the supplier to the primary GTL or associate GTL and SME) as a potential civil monetary penalty case.

CMS will not accept any other certifications of medical necessity by other insurers or government agencies.

Suppliers and physician may choose to utilize electronic CMNs (e-CMNs) or electronic DIFs (e-DIFs). E-CMNs or e-DIFS must adhere to all privacy, security, and electronic signature rules and regulations promulgated by CMS and DHHS. Additionally, e-CMNs or e-DIFs must contain identical questions/wording to the CMS forms, in the same sequence, with the same pagination,

and identical instructions/definitions as printed on the back of the hardcopy form.

If an item requires a CMN or a DIF and the supplier does not have a faxed, photocopied, original hardcopy, or an electronic signed CMN or DIF in their records when they submit a claim to Medicare, the claim will be denied.

In cases where two or more suppliers merge, the resultant supplier should make all reasonable attempts to secure copies of all active CMNs or DIFs from the supplier(s) purchased. This document should be kept on file by the resultant supplier for future presentation to the DME MACs, and *UPICs*.

When reviewing claims where the medical record contains a copied, faxed or electronically maintained CMN or DIF (any CMN or DIF created, modified, and stored via electronic means such as commercially available software packages and servers), the DME MACs, or *UPICs* must accept the copied, faxed or electronic document as fulfilling the requirements for these documents.

When a *UPIC* is investigating potentially fraudulent behavior by a supplier, it will be the supplier's responsibility to prove the authenticity/validity of the claim(s) under investigation. *UPICs* may require the supplier to prove the authenticity/validity of the signature on the CMN, DIF, order, or any other questionable portion of the claim(s) under investigation.

Upon request by the DME MACs, *UPICs*, SMRC or DME RACs, suppliers must provide the CMN or DIF, in a format that the DME MACs, *UPICs*, SMRC, and DME RACs can accept, in a timely manner. Upon medical review, the DME MACs, *UPICs*, SMRC, and DME RACs should not deny claims solely because the CMN or DIF is faxed, copied, or electronic. The DME MACs, *UPICs*, SMRC, and DME RACs may request the supplier to download and print a hard copy of an electronic order, CMN or DIF if the DME MACs, *UPICs*, SMRC, and DME RACs cannot access it electronically.

For items that require a CMN, and for accessories, supplies, and drugs related to an item requiring a CMN, the CMN may serve as the written order if the narrative description in Section C is sufficiently detailed (as described above). This applies to both hard copy and electronic orders or CMNs. A DIF does not contain a section for a narrative description and is not applicable.

A supplier must have a hard copied, faxed or electronic order, CMN or DIF in their records when they can submit a claim for payment to Medicare. Suppliers must ensure the security and integrity of electronically maintained CMNs or DIFs are in accordance with any regulations published by CMS.

The DME MACs or *UPICs* need not make any shared system changes to electronically accept e-CMNs or e-DIFS as CMS views e-CMNs or e-DIFs as a transaction between the physician and suppliers. Suppliers must continue to use current systems for transmitting claim information to the DME MAC or *UPICs*.

5.3.1 - Completing a CMN or DIF

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

The "Initial Date" found in Section A of the CMN, should be either the specific date that the physician gives as the start of the medical necessity or, if the physician does not give a specific start date, the "Initial Date" would be the date of the order.

The "Signature Date" is the date the physician signed and dated Section D of the CMN. This date might not be the same as the "Initial Date", since the "Signature Date" must indicate when the physician signed Section D of the CMN. Medicare requires a legible identifier for services provided/ordered. The method used shall be handwritten or an electronic signature in accordance with chapter 3, section 3.4.1.1 to sign an order or other medical record documentation for medical review purposes. Signature and date stamps are not acceptable for use on CMNs and DIFs.

The "Delivery Date/Date of Service" on the claim must not precede the "Initial Date" on the CMN or DIF or the start date on the written order. To ensure that an item is still medically necessary, the delivery date/date of service must be within 3 months from the "Initial Date" of the CMN or DIF or 3 months from the date of the physician's signature.

The DME MACs and *UPICs* have the authority to request to verify the information on a CMN or DIF at any time. If the information contained either in the supplier's records or in the patient's medical record maintained by the ordering physician fails to substantiate the CMN or DIF, or if it appears that the CMN or DIF has been altered, the DME MACs and *UPICs* should deny the service and initiate the appropriate administrative or corrective actions.

In the event of a post pay audit, the supplier must be able to produce the CMN or DIF and, if requested by the DME MACs and *UPICs* DME produce information to substantiate the information on the CMN or DIF. If the supplier cannot produce this information, the DME MACs and *UPICs* should deny the service and initiate the appropriate administrative or corrective actions.

If there is a change made to any section of the CMN after the physician has signed the CMN, the physician must line through the error, initial and date the correction; or the supplier may choose to have the physician complete a new CMN.

5.3.2 - Cover Letters for CMNs

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

Cover letters can be used by a supplier as a method of communication between the supplier and the physician. It is not CMS's intent to restrict necessary communication between the supplier and the physician. CMS does not require nor regulate the cover letter. The DME MACs and *UPICs* should not take adverse action against suppliers that solely involve cover letters.

The DME MACs should regularly publish an article in their bulletins asking suppliers to remind physicians and suppliers of their responsibility in completing and signing the CMN or DIF. It is the physician's and supplier's responsibility to determine both the medical need for, and the utilization of, all health care services. The physician and supplier should ensure that information relating to the beneficiary's condition is correct. The DME MAC and *UPICs* should encourage suppliers to include language in their cover letters to remind physicians of their responsibilities.

5.4 - DME MACs and *UPICs* Authority to Initiate an Overpayment and/or Civil Monetary Penalty (CMP) When Invalid CMNs or DIFs Are Identified

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

Section 1862(a)(1)(A) of the Act prohibits Medicare payment for services that are not reasonable and necessary. Section 1833(e) of the Act requires that Medicare be furnished by providers and

suppliers "such information as may be necessary in order to determine the amount due.…" These sections provide support that a failure to have a valid CMN or DIF on file or to submit a valid CMN or DIF to the DME MACs and *UPICs* makes the underlying claim improper because Medicare does not have sufficient information to determine whether the claim is reasonable and necessary. A valid CMN is one in which the treating physician has attested to and signed supporting the medical need for the item, and the appropriate individuals have completed the medical portion of the CMN. A valid DIF is one in which the supplier has attested to and signed supporting the medical need for the item. When the DME MACs and *UPICs* identify a claim for which a CMN or DIF is not valid, they may deny the claim and/or initiate overpayment action.

If a DME MAC and *UPICs* identifies a supplier that has a pattern of improperly completing the CMN or DIF, the DME MAC or *UPICs* may choose to initiate a potential Civil Monetary Penalty (CMP) case against the supplier. The authority for such action is found in §1834(j)(2)(A)(iii) of the Act which states that "any supplier of medical equipment and supplies who knowingly and willfully distributes a CMN in violation of clause (I) or fails to provide the information required under clause (ii) is subject to a civil money penalty in an amount not to exceed $1,000 for each such certificate of medical necessity so distributed." The provisions of §1128A of the Act (other than subsections (a) and (b) shall apply to CMPs penalties under this subparagraph in the same manner as they apply to a penalty or proceeding under §1128(A)(a)) of the Act.

5.7 - Documentation in the Patient's Medical Record

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

For any DMEPOS item to be covered by Medicare, the patient's medical record must contain sufficient documentation of the patient's medical condition to substantiate the necessity for the type and quantity of items ordered and for the frequency of use or replacement (if applicable). The information should include the patient's diagnosis and other pertinent information including, but not limited to, duration of the patient's condition, clinical course (worsening or improvement), prognosis, nature and extent of functional limitations, other therapeutic interventions and results, past experience with related items, etc. If an item requires a CMN or DIF, it is recommended that a copy of the completed CMN or DIF be kept in the patient's record. However, neither a physician's order nor a CMN nor a DIF nor a supplier prepared statement nor a physician attestation by itself provides sufficient documentation of medical necessity, even though it is signed by the treating physician or supplier. There must be information in the patient's medical record that supports the medical necessity for the item and substantiates the answers on the CMN (if applicable) or DIF (if applicable) or information on a supplier prepared statement or physician attestation (if applicable). When a CMN or DIF and a medical record contain conflicting information due to a minor error or omission within the CMN or DIF, but all coverage, coding and payment criteria are substantiated through the medical record, the reviewer shall rely upon the content of the medical record (absent suspicion of abuse or gaming) and shall not issue a denial.

See PIM, chapter 3, section 3.4.1.1, for additional instructions regarding review of documentation during pre- and post-payment review.

The patient's medical record is not limited to the physician's office records. It may include hospital, nursing home, or HHA records and records from other health care professionals.

The documentation in the patient's medical record does not have to be routinely sent to the supplier or to the DME MACs and *UPICs*. However, the DME MACs and *UPICs* may request this information in selected cases. If the DME and *UPICs* do not receive the information when

requested or if the information in the patient's medical record does not adequately support the medical necessity for the item, then on assigned claims the supplier is liable for the dollar amount involved unless a properly executed advance beneficiary notice (ABN) of possible denial has been obtained.

5.9 - Evidence of Medical Necessity

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

If replacement supplies are needed for the therapeutic use of purchased DMEPOS, the treating physician must specify on the order, or on the CMN, the type of supplies needed and the frequency with which they must be replaced, used, or consumed. DME MACs and *UPICs* evaluate supply utilization information as part of the medical necessity determination for DMEPOS. They do not accept "PRN" or "as needed" utilization estimates for supply replacement, use, or consumption.

Absent a State law to the contrary or a supply utilization problem, the order or CMN submitted for the DMEPOS may also serve as medical evidence for supply replacement claims. However, when an order for DMEPOS is renewed or revised, supply utilization information must be specified or updated by the physician on the CMN. DME MACs and *UPICs* assess the continuing medical necessity.

The DME MACs and *UPICs* must establish procedures for monitoring the utilization of replacement supplies. Suppliers must have documentation to support the medical necessity of changes in the equipment, device, or supply utilization requirements. Absent such notification, DME MACs and *UPICs* do not allow claims for unexplained increases in supply utilization above the usage level they previously determined as medically necessary. Suppliers shall make this information available to the DME MACs and *UPICs* on request.

If necessary or appropriate for a medical necessity determination, the DME MAC and *UPICs* must ask the supplier to obtain documentation from the treating physician, establishing the severity of the patient's condition and the immediate and long term need for the equipment and the therapeutic benefits the patient is expected to realize from its use. A claim of therapeutic effectiveness or benefit based on speculation or theory alone cannot be accepted. When restoration of function is cited as a reason for use of DMEPOS, the exact nature of the deformity or medical problem should be clear from the medical evidence submitted. Also, the manner in which the equipment or device will restore or improve the bodily function should be explained by the treating physician.

If the DME MAC and *UPICs* is unsuccessful in obtaining medical information from the supplier for non-assigned claims, it gives the beneficiary the opportunity to obtain the desired information from the supplier. If, after obtaining the requested information, a question of medical necessity remains, the DME MAC and *UPICs* must resolve the issue.

5.9.1 - Evidence of Medical Necessity for the Oxygen Claims

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

If DME MACs, CERT, *UPICs*, Recovery Auditors or the SMRC learn that the physician of record is no longer the treating physician, the supplier shall obtain from the physician currently responsible for the patient's pulmonary condition a current fully-completed oxygen CMN. After review of this oxygen CMN, DME MACs continue monthly payments if the evidence establishes medical necessity. Their records must be updated to identify the new treating physician.

For an initial claim, the physician must submit a signed certification of medical necessity that includes an oxygen/blood gas lab result. This certification must be corroborated with information in the medical record. A physician signature on the oxygen lab test result is not necessary to corroborate the certification. Instead, the reviewer should consider all submitted records from all of the beneficiary's healthcare professionals.

Therefore, contractors shall not deny an oxygen or oxygen equipment claim solely because the claim lacks a physician signature on the oxygen lab test result.

5.10 - Period of Medical Necessity - Home Dialysis Equipment

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

Situations may occur causing temporary non-use of equipment:

- Beneficiary requires in-facility treatment for re-stabilization or as a result of some acute condition. The beneficiary is expected to return to home dialysis;

- Beneficiary is temporarily without a suitable home dialysis assistant;

- Beneficiary is away from home but expects to return; or

- Beneficiary is a transplant candidate and is taken off home dialysis preparatory to transplant. (If the transplant cannot occur, or if the transplant is not successful, the patient will very likely resume home dialysis and an evaluation can be made whether it will be within the immediate or foreseeable future.)

Under such circumstances, DME MACs and *UPICs* determine that medical necessity exists and pay for a period of up to 3 months after the month home dialysis equipment was last used. This does not eliminate the necessity for periodic reevaluation of medical necessity. It provides a tolerance to avoid frequent reevaluation in renal dialysis situations and provides for continuity of payments where economically advantageous.

5.11 - Safeguards in Making Monthly Payments

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

The DME MACs and *UPICs* shall establish appropriate safeguards to assure that payments are not made beyond the last month of medical necessity. They must develop appropriate safeguards to identify and investigate the following:

- Multiple claims for rental of the same or similar equipment from the same supplier within the same rental month (e.g., rental claims with different start dates but within the same rental period); Pub. 100-04, chapter 20, §30.5 specifically forbids payments for multiple claims for rental of the same or similar equipment from either the same or a different supplier during the same rental month;

- Contraindicated items of rented or purchased equipment;

- Incompatible claims information (e.g., liquid oxygen contents billed for a purchased gas delivery system);

- Medical equipment rentals or purchases after a beneficiary's death;

- Rental start dates on or after the purchase of the same or comparable equipment (absent evidence that the beneficiary has disposed of purchased equipment);

- Rental claims for the same or similar equipment from different suppliers for the same or overlapping rental months; and

- Equipment rental start dates within periods of confinement in an institution that cannot be considered a patient's home.

The DME MACs and *UPICs* shall resolve these situations on a prepayment basis. Development, if necessary, may be via written or telephone contact per Pub. 100-08 subject to any other documentation or development guidelines specified in Pub. 100-02, chapter 15, §100-01, Pub. 100-04, chapter 20, §10.1.1 and Pub. 100-04, chapter 20, §100.2.3.

To the extent possible, DME MACs and *UPICs* give beneficiaries and supplier- assignees advance notice of the date and reason that payments are scheduled to stop. (See Pub. 100-04, chapter 21 for EOMB language.)

5.12 - Pick-up Slips

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

For purposes of this section, a pick-up slip is written confirmation, provided by a supplier, that the supplier has removed an item of DME from the beneficiary’s home.

When making determinations, DME MACs and *UPICs* must ascertain not only whether equipment is present in the home, but must determine which equipment is actually being used by the patient. Therefore, it is inappropriate to determine, solely based on lack of a pick up slip that a piece of equipment may still be in use. Likewise, it is inappropriate for DME MACs and *UPICs* should develop these claims to determine which piece of equipment is medically necessary.

5.16 - Advance Determination of Medicare Coverage (ADMC) of Customized DME

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

Section 1834(a)(15)(C) of the Act provides that carriers shall, at the request of a supplier or beneficiary, determine in advance of delivery of an item whether payment for the item may not be made because the item is not covered if:

- The item is a customized item,

- The patient to whom the item is to be furnished, or the supplier, requests that such advance determination be made, and

- The item is not an inexpensive item as specified by the Secretary.

This section provides for direction in implementing §1834 (a)(15)(C) of the Act. It is important to note that ADMCs are not initial determinations as defined at 42 CFR 405.801(a), because no request for payment is being made. As such, an ADMC cannot be appealed.

This is a voluntary program. Beneficiaries and suppliers are not required to submit ADMC requests in order to submit claims for items. Additionally, *UPICs* may not require an ADMC request as a prerequisite for submitting a claim.

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Chapter 6 – Medicare Contractor Medical Review Guidelines for Specific Services

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(Rev. 10228; Issued: 07-27-20)

6.5.6 - Length-of-Stay Review

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

The contractor shall determine whether the length-of-stay for PPS cost outlier claims and specialty hospital/unit claims, when selected for medical review, is appropriate and medically necessary. Identify cases of potential delayed discharge. For example, the beneficiary was medically stable, and continued hospitalization was unnecessary, or nursing home placement or discharge to home with home care would have been appropriate in providing needed care without posing a threat to the safety or health of the beneficiary (see §4110).

If Medicare payment is applicable to only part of the stay, review the covered portion of the stay and enough of the rest of the medical record (if necessary) to answer any specific questions that may arise from review of the covered part of the stay. If a beneficiary became Medicare eligible during a hospital stay, review enough of the medical record prior to the initiation of Medicare benefits to acquire sufficient information to make a determination. Do not perform lengthy reviews of non-covered care. In PPS waived/excluded areas, length-of-stay review is performed for all inpatient admissions that are selected for medical review.

The contractor shall determine whether the length of stay was appropriate for claims selected for medical review that represent PPS cost outliers. However, the contractor shall not include days on which care is determined not to have been medically necessary in the calculation of outlier payments. Where it is determined that a beneficiary's stay was unnecessarily long, and potentially represents fraud or abuse, the contractor shall make a referral to the *UPIC*.

6.5.9 - Circumvention of PPS

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

If you suspect, during review of a claim associated with a transfer or readmission, that a provider of Medicare services took an action with the intent of circumventing PPS (as described in §1886(f)(2) of the Act) and that action resulted in unnecessary admissions, premature discharges and readmissions, multiple readmissions, or other inappropriate medical or other practices with respect to beneficiaries or billing for services, you shall make a referral to your *Unified Program Integrity Contractor (UPIC)*.

6.6 - Referrals to the Quality Improvement Organization (QIO)

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

The MACs shall only refer Quality of (Health) Care Concerns to the QIOs. A Quality of (Health) Care Concern is defined as "a concern that care provided did not meet a professionally recognized standard of health care." The Contractor shall follow the referral process as agreed upon in the QIO-MAC Joint Operating Agreement. The QIOs will retain their responsibility for performing expedited determinations, Hospital-Issued Notices of Non-Coverage (HINN) reviews, quality reviews, transfer reviews, readmission reviews and, provider-requested higher-weighted DRG reviews.

The Circumvention of PPS will continue to be reported to your *UPIC*. The quality initiatives associated with payment for performance are now the reporting source for Readmission Reviews and Transfer Review data to the QIOs. Non-covered benefits/services are not to be reported to the QIO.

All initial payment determinations and claim adjustments are required to be performed by the

MAC.

All MACs are to turn off all automated edits/processes that generate a referral to the QIOs prior to a medical record review of the claim. Referrals to the QIO shall be limited to Quality of Health Care issues as defined above and shall result from a clinician's medical record review of a provider's medical documentation.

If during the medical record review process, "a concern that care provided did not meet a professionally recognized standard of health care," the MAC shall issue a payment determination and/or adjustment for the claim, complete the QIO referral form, and forward the completed referral form and file(s) to the QIO. If the referral form is not complete, the QIO will return the file to the MAC and request that the MAC provide the missing information prior to the QIO performing a review.

A non-covered service and/or procedure shall not be automatically referred to the QIO. The MAC shall make the initial payment determination and/or claim adjustment for a non-covered service or procedure in accordance with the Medicare IOM 100-04, Claims Processing Manual and IOM 100-02, Benefit Policy Manual.

If during the medical record review process, "a concern that care provided did not meet a professionally recognized standard of health care," such as a medically unnecessary procedure, the claim shall be referred to the QIO for quality review after payment determination and/or claim adjustment is made.

The MACs shall not instruct providers, suppliers, or beneficiaries to refer payment issues to the QIO. If the provider or supplier does not agree with the payment and/or claim adjustment decision, the MAC shall communicate their options to follow the current process in IOM 100-08, requesting a reopening or an appeal. If the beneficiary disagrees with the payment decision and makes a request for re-evaluation/redetermination, this will be considered a demand bill and is the responsibility of the MAC.

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Chapter 7 – MR Reports

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(Rev. 10228; Issued:07-27-20)

7.1.2.5 - MR Activities and Improper Payment Interventions Planning

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

For each prioritized problem, the MAC shall develop a comprehensive plan of MR activities and other improper payment interventions using the Progressive Corrective Action (PCA) process. The MAC shall develop multiple tools to effectively address identified problems. The scope and severity of the identified problems shall determine the MR activities and improper payment interventions needed to successfully address the problems.

The MR activities and improper payment interventions shall be tailored to the nature of the problem. Existing interventions that have proven effective in reducing improper payments shall be used as one basis for the implementing of MR activities and other improper payment interventions. The effectiveness of existing MR activities and other improper payment interventions shall be explained in discrete figures and/or improper payment rates.

The MAC shall include an estimated date of implementation for each planned MR activity and improper payment intervention.

The MR activities and improper payment interventions may include, but are not limited to:

- MR Activities
- Provider or service-specific probes
- Targeted medical reviews (TMRs)
- Notification letters
- POE priority referrals
- Automated denials based on local coverage determinations (LCDs)
- Edit modifications
- Post-payment and statically valid random sampling (SVRS) extrapolation
- Development or revisions of LCDs
- Probe review education
- POE activities
- Recalcitrant provider process

The MAC shall describe the process for provider selection for MR activities and other improper payment interventions. For example, the MAC may describe review criteria in the following manner: “Providers whose denied claims represent over x percent of the dollar amount reviewed will be placed on a prepay review or providers who have a provider error rate > x percent will be placed on an x percent prepay review.”

If initial MR activities and improper payment interventions are insufficient to improve the provider’s billing behavior, a priority referral to POE for potential intervention may be necessary. A POE priority referral indicates to the POE department that this is a problem which MR has determined will likely require further educational intervention.

Through communication with POE, it is determined that MR activities, improper payment interventions and POE educational efforts have not effectively resolved the problem, a referral to the *Unified Program Integrity Contractors (UPIC)*, Recovery Auditor or the recalcitrant process may be indicated.

If an improper payment intervention is to refer the provider to another entity, i.e., Recovery Auditor, *UPIC*, or Quality Improvement Organization (QIO), the MAC shall have backup MR activities or improper payment interventions if the referral is not accepted by the other entity.

The MR department shall employ an effective follow-up process that ensures appropriate resolution of the issue. If provider billing aberrances continue, the MAC shall use information obtained via consultation with other areas of the MAC which shall include the POE department to develop a revised comprehensive plan of MR activities and other improper payment interventions using the PCA process. This plan may involve increases in MR prepay review or conducting Statistical Sampling for Overpayment Estimation (SSOE). As issues are successfully resolved, the MAC shall continue to address other program errors/vulnerabilities identified on the prioritized problem list.

The MAC MR department shall have a system to track all referrals to POE, medical review activities, and improper payment interventions used to address identified problems. The MAC MR shall work with POE to develop an effective tracking system for referred problems. The Contractor shall track all contacts made by their MR unit with providers, *UPICs*, and Recovery Auditors during the course of medical review.

7.2.2.7 - Prepay Provider Specific Probe Medical Record Review

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

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

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

7.2.2.8 - Prepay Service Specific Probe Medical Record Review

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

Medical record review requires a licensed medical professional to use clinical review judgment to evaluate medical records. Prepay service specific probe medical record reviews are done to verify that the program vulnerability identified through data analysis actually exists and will require education and possible targeted medical review. For Prepay review in the case of a possible systemic problem, the contractor shall include a random or stratified sample of generally 100 claims submitted from across all providers or suppliers that bill the particular item or service in question.

The Contractor shall validate data analysis findings by conducting probe reviews and implementing the necessary PCAs in accordance with IOM Pub.100-08 Chapter 3. Once a problem has been verified, the Contractor shall implement the necessary PCA. This includes providing the initial notification of the results of the probe review, and collaborating with

Provider Outreach and Education (POE) to share potential educational needs, and making referrals to POE, *UPICs*, RACs or others as appropriate.

7.2.2.10 - Postpay Provider Specific Probe Medical Record Review

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

Medical record review requires a licensed medical professional to use clinical review judgment to evaluate medical records. Postpay provider specific probe medical record reviews are done to verify that the program vulnerabilities identified through data analysis actually exist and will require education and/or further medical review. For postpay review of an individual provider in the case of a possible provider specific problem, contractors shall include in the probe sample a random or stratified sample of generally 20 -40 claims from that provider with dates of service from the period under review.

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

7.2.2.11 - Postpay Service Specific Probe Medical Record Review

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

Medical record review requires a licensed medical professional to use clinical review judgment to evaluate medical records. Postpay service specific probe medical record reviews are done to verify that the program vulnerabilities identified through data analysis actually exist and will require education and/or further medical review. For Postpay review in the case of a possible service/systemic problem, the contractor should generally include a random or stratified sample of 100 claims with dates of service from the period under review from across all providers or suppliers that bill the particular item or service in question.

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

7.2.2.16 - Externally Directed Reviews

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

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

Medicare Program Integrity Manual

Chapter 8 – Administrative Actions and Sanctions and Statistical Sampling for Overpayment Estimation

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(Rev. 10228; Issued; 07-27-20)

Transmittals for Chapter 8

8.1 - Appeal of Denials

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

A claimant dissatisfied with a contractor's initial determination is entitled by law and regulations to specified appeals. The appeals process allows a provider and/or a beneficiary (or representative) the right to request a review or reconsideration of the determination to deny a service in full or in part. In this process, Hearing Officers (HOs) and ALJs look to the evidence of record and must base their decision upon a preponderance of the evidence. If the appeal is of a claim reviewed by a *UPIC*, then the *UPIC* forwards its records on the case to the AC so that it can handle the appeal.

As conclusory statements may be considered of little or questionable value, it is important that reviewers include clearly articulated rationale for their findings. Such clearly articulated rationale will continue to be of importance if a denial is appealed beyond the ALJ level to the Appeals Council or eventually to federal court. Contractors must include a copy of the policy underlying denial in the case file.

A. Use of Medical Specialist

Reviewers may also use medical specialists to lend more weight and credibility to their rationale or findings. When an adjudicator must weigh the statements and rationale furnished by the appellant provider against the statements and rationale of the reviewer (and any information used by the reviewer), the opinion of a specialist in the same area as the provider may carry greater weight than the opinion of a non-specialist.

Consequently, *UPICs* are required to have a medical specialist involved in denials that are not based on the application of clearly articulated policy with clearly articulated rationale. A review or reconsideration involving the use of medical judgment should involve consultation with a medical specialist. Additionally, contractors are encouraged to use specialists whenever possible since providers are more likely to accept the opinion (and any resulting overpayment) of a specialist in their own area.

B. Documenting Reopening and Good Cause

Reopening occurs when a *UPIC* conducts a review of claims at any time after the initial/review determination (see 42 CFR 405.980, (b).) If reopening and conducting a postpayment review occurs within 12 months of the initial/review determination, the *UPIC* does not need to establish good cause. However, the *UPIC* should document the date so there is no confusion about whether good cause should have been established. After 12 months, but within 4 years from the date of the initial/review determination, contractors must establish good cause. (See Medicare Claims Processing Manual Pub 100-04, chapter 34 and 42 CFR 405.986. Documenting the date a claim was reopened (regardless of the demand letter issue date) and the rationale for good cause when claims are reopened more than 12 months from the initial/review determination will lend credibility to contractor documentation if the determination is appealed.

8.2 - Overpayment Procedures

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

This section applies to Medicare Administrative Contractors (MACs) and *Unified Program Integrity Contractors (UPICs)*.

The *UPIC* shall refer all identified overpayments to the MAC who shall send the demand letter and recoup the overpayment.

Contractors should initiate recovery of overpayments whenever it is determined that Medicare has erroneously paid. In any case involving an overpayment, even where there is a strong likelihood of fraud, contractors shall request recovery of the overpayment.

The *UPIC* shall refer such overpayments to the MAC only after the investigation has been vetted with CMS (see Pub. 100-08, chapter 4, section 4.6.4). In addition, if a *UPIC* is making a referral to law enforcement, it shall refrain from referring the overpayment determination to the MAC during specified times noted in Pub. 100-08, chapter 4, section 4.18. If a large number of claims are involved, contractors consider using statistical sampling for overpayment estimation to calculate the amount of the overpayment. (See section 8.4 of this chapter.)

Contractors have the option to request the periodic production of records or supporting documentation for a limited sample of submitted claims from providers or suppliers to which amounts were previously overpaid to ensure that the practice leading to the overpayment is not continuing. The MAC may take any appropriate remedial action described in this chapter if a provider or supplier continues to have a high level of payment error. Offer the provider a consent settlement based on the potential projected overpayment amount.

8.2.3.2 - Conduct of Expanded Review Based on Statistical Sampling for Overpayment Estimation and Recoupment of Projected Overpayment by Contractors

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

The MACs shall perform the actual recoupment identified by the *UPICs*. When a *UPIC* or medical review audit determines an extrapolated overpayment the sample claims reviewed are adjusted for denial. For history purposes, contractors shall deny the sample claims individually in the shared system and shall suppress the sample claims from going to HIGLAS. Once the entire extrapolated amount is identified, contractors shall create one large account receivable (AR) for the extrapolated amount (including the adjusted sample claim amounts) to demand and recoup.

A. If an expanded review of claims is conducted, contractors shall follow the sampling instructions found in section 8.4 of this chapter, obtain and review claims and medical records, and document for each claim reviewed:

- The amount of the original claim;
- The allowed amount;
- The rationale for denial;
- The §1879 determination for each assigned claim in the sample denied because the service was not medically reasonable and necessary (or the §1842(1) provider/supplier refund determination on non-assigned provider/supplier claims denied on the basis of §1862(a)(1)(A)) (refer to Exhibit 14.1 of this manual);
- The §1870 determination for the provider/supplier for each overpaid assigned claim in the sample (refer to Exhibit 14.2 of this manual); and

- The amount of overpayment (after allowance for deductible and coinsurance).

B. Contractors calculate the projected overpayment by extrapolating from the actual overpayment to the universe that excludes those claims determined that the provider/supplier did not have knowledge that the service was not medically necessary;

C. Notify the provider/supplier of the preliminary projected overpayment findings and review findings;

D. If the provider/supplier submits additional documentation, review the material and adjust the preliminary projected overpayment findings, accordingly;

E. Calculate the final overpayment; and

F. Refer to the overpayment recoupment staff.

8.2.3.3.1 - Background on Consent Settlement

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 defines consent settlement as an agreement between the Secretary and a provider of services or supplier whereby both parties agree to settle a projected overpayment based on less than a statistically valid sample of claims and the provider of services or supplier agrees not to appeal the claims involved. The *UPICs* and the contractor medical review units shall submit via secure email the consent settlement to the Primary and Associate GTLs before offering a consent settlement to the provider or supplier. If the *UPICs* or the contractor medical review units do not have secure email, the consent settlement shall be sent to the Primary GTL and the Associate GTL via hard copy. Upon receipt, GTLs will forward the consent settlement to the Director of the Division of Benefit Integrity Management Operations. The *UPICs* and the contractor medical review units may contact the provider upon approval of the consent settlement. Consent settlement documents carefully explain, in a neutral tone, what rights a provider waives by accepting a consent settlement. The documents shall also explain in a neutral tone the consequences of not accepting a consent settlement. A key feature of a consent settlement is a binding statement that the provider agrees to waive any rights to appeal the decision regarding the potential overpayment. The consent settlement agreement shall carefully explain this, to ensure that the provider is knowingly and intentionally agreeing to a waiver of rights. Consent settlement correspondence shall contain:

1. A complete explanation of the review and the review findings*;*

2. A thorough discussion of §1879 and §1870 determinations, where applicable*;*

3. The consequences of deciding to accept or decline the consent settlement offer*; and*

4. It is rare that a *UPIC* will offer and develop a consent settlement.

However, when the *UPIC* offers and develops a consent settlement, the AC or MAC shall administer the settlement.

8.2.3.3.3 - Consent Settlement Offer

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

After the additional information concerning the medical records for the claims reviewed have been assessed and if it is still determined that there was an overpayment, the contractor shall offer the provider or supplier the opportunity to proceed with statistical sampling for overpayment estimation or a consent settlement. The *UPICs* and the contractor medical review units may choose to present the consent settlement letter to the provider or supplier in a face-to-face meeting. The consent settlement correspondence shall describe the two options available to the provider or supplier. The provider or supplier is given 60 days from the date of the correspondence to choose an option. If there is no response, Option 1 shall be selected by default.

8.2.3.3.4 - Option 1 - Election to Proceed to Statistical Sampling for Overpayment Estimation

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

If a provider or supplier fails to respond, this option shall be selected by default. For providers or suppliers who select this option knowingly or by default, thereby rejecting the consent settlement offer and retaining their full appeal rights, *UPICs* and the contractor medical review units shall:

- Notify the provider or supplier of the actual overpayment and refer to overpayment recoupment staff; and

- Initiate statistical sampling for overpayment estimation of the provider's or supplier's claims for the service under review following instructions in the Program Integrity Manual, chapter 8, §8.4

If the review results in a decision to recoup the overpayment, the overpayment collection shall be initiated within 12 months of the decision.

8.2.3.3.6 - Consent Settlement Budget and Performance Requirements for ACs

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

When supporting *UPICs* in consent settlements, the ACs shall report these costs in the *UPIC* support activity code 23201.

8.3 - Suspension of Payment

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

This section applies to Medicare Administrative Contractors (MACs) and *Unified Program Integrity Contractors (UPICs)*.

Hereinafter, suspension of payment may be referenced as "payment suspension."

Requests for Suspension of Payment ("Payment Suspension") may be approved when there is reliable information that an overpayment exists, when payments to be made may not be correct, or when there is a credible allegation of fraud existing against a provider. The process by which the *UPIC* notifies and coordinates with the MAC to implement a CMS-approved suspension of payment shall be documented in the Joint Operating Agreement (JOA) between the MAC and the *UPIC*. The *UPICs* shall advise and coordinate the imposition of a payment suspension with the appropriate MAC when a payment suspension has been approved by CMS. The *UPIC* shall

perform the necessary medical review and development of overpayments for payment suspensions that have received CMS approval, when appropriate.

Medicare authority to withhold payment in whole or in part for claims otherwise determined to be payable is found in federal regulations at 42 CFR §405.370-375, which provide for the suspension of payments.

All payment suspensions shall be referred to the CMS/Center for Program Integrity (CPI) via the Fraud Investigation Database (FID) for approval. *UPICs* shall notify their appropriate CPI Contracting Officer's Representative (COR)/Business Function Lead (BFL) of the submission by providing the FID number via email.

8.3.1 - When Suspension of Payment May Be Used

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

A payment suspension may be used when there is:

Reliable information that an overpayment exists, but the amount of the overpayment is not yet determined;

Reliable information that the payments to be made may not be correct;

Reliable information that the provider fails to furnish records and other essential information necessary to determine the amounts due to the provider;

In cases of suspected fraud, a payment suspension may be used when there is a credible allegation of fraud.

These above reasons for implementing a payment suspension are described more fully below.

NOTE: If a payment suspension is approved, this edit of withholding of Medicare funds takes precedent over any other edits withholding money in the MAC systems. When it is time to terminate the payment suspension, the withheld funds must first be applied to the Medicare overpayment(s) and any excess is then applied to any other outstanding overpayments or debts owed to CMS or HHS in accordance with 42 CFR §405.372(e), unless otherwise directed by CMS.

NOTE: For providers that file cost reports, a payment suspension may have little impact. If the provider is receiving periodic interim payments (PIP), the interim payments may be suspended. If the provider is not receiving PIPs, a payment suspension will affect the settlement of the cost report. When an overpayment is determined, the amount is not included in any settlement amount on the cost report. For example, if the A/B MAC (A) has withheld (suspended) $100,000 when the cost report is settled, the A/B MAC (A) would continue to hold the $100,000. This means that if the cost report shows the Medicare program owing the provider $150,000, the provider would only receive $50,000 until the payment suspension action has been terminated. If the provider owes the Medicare program money at settlement, the amount of the suspended payment would increase the amount owed by the provider. In most instances, A/B MACs (A) should adjust interim payments to reflect projected cost reductions. The contractors are to limit the adjustment to the percentage of potential fraud or the total payable amount for any other reasons. For example, if the potential fraud involved five percent of the periodic interim rate, the reduction in payment is not to exceed five percent. Occasionally, suspension of all interim payments may be appropriate.

NOTE: If a payment suspension is approved for a home health agency, all Requests for Anticipated Payments (RAPs) are to be suppressed (disapproved) in accordance with 42 C.F.R. §409.43(c)(2). The *UPIC* shall make this request to CPI as part of its request for a payment suspension.

In addition, CMS may suppress RAP payments for program integrity concerns absent a payment suspension. If the *UPIC* determines that a RAP suppression is appropriate they shall submit the following information to CMS:

- Are final bills being submitted by the HHA? Yes or No
- Indicate the volume (dollar and number of claims) of RAPs for the past 12 months.
- A brief summary supporting the request for RAP suppression.

8.3.1.1 - Credible Allegation of Fraud Exists Against a Provider - Fraud Suspensions

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

A payment suspension may be used when the *UPIC*, law enforcement, or CMS determines that a credible allegation of fraud exists against a provider or supplier (hereinafter referred to as provider). For purposes of section 8.3 et seq., these types of payment suspensions will be called "fraud suspensions."

Fraud suspensions may also be imposed for reasons not typically viewed within the context of false claims. For example:

- The Quality Improvement Organization (QIO) has reviewed inpatient claims and determined that the diagnosis related groups (DRGs) have been upcoded.

- The *UPIC* or MAC may suspect a violation of the physician self-referral ban. For this reason, the violation may be considered the cause for a payment suspension since claims submitted in violation of this statutory provision must be denied and any payments made would constitute an overpayment.

- Even though services are rendered and may be determined as medically necessary and reasonable by the Medicare contractor, law enforcement has credible allegations of kickbacks.

- Forged signatures on medical record documentation (e.g., Certificates of Medical Necessity (CMN), treatment plans, etc.) and/or other misrepresentations on Medicare claims or associated forms to obtain payment that would result in an overpayment determination.

Whether or not the *UPIC* recommends a payment suspension to CMS, the final determination is determined on a case-by-case basis and requires review and analysis of the allegation and facts. The following information is provided to assist the *UPIC* in deciding when to recommend a payment suspension to CPI.

A. Complaints

There is considerable latitude with regard to complaints alleging fraud, waste, and abuse. The provider's Medicare history, including the volume and frequency of complaints concerning the provider, and the nature of the complaints all contribute to whether a payment suspension should

be referred to CPI. If there is a credible allegation(s) that a provider is submitting or may have submitted false claims, the *UPIC* may recommend a fraud suspension to CPI only after the *UPIC* has vetted the provider in accordance with Pub. 100-08, chapter 4, section 4.6.4. (If the MAC identifies the potential fraud issue from a complaint, the MAC shall refer its information to the respective *UPIC* for development).

B. Requests for Suspension of Payment

For initial *UPIC* requests to suspend payments, the *UPIC* shall inform its assigned BFL of the potential suspension. The BFL will discuss all findings with the *UPIC*. After informing the BFL about the suspension, the contractor shall submit the payment suspension request via the FID if the contractor determines such action is warranted. The Payment Suspension Administrative Action Request (AAR), draft suspension notice, and all other relevant documentation that supports the suspension request shall be uploaded by the contractor as part of the FID submission.

The *UPIC* shall also prepare and submit, if appropriate, a payment suspension referral package to CPI via the FID for all requests received from (but not limited to):

- CMS
- Office of Inspector General (OIG)
- Federal Bureau of Investigation (FBI)
- Assistant United States Attorney (AUSA)
- Other law enforcement agencies

C. Other Situations

Other situations that may be considered when recommending a fraud suspension to CPI include, but are not limited to:

- Provider has pled guilty to, or been convicted of, Medicare, Medicaid, TRICARE, or private health care fraud and is still billing Medicare for services;
- Federal/State law enforcement has subpoenaed the records of, or executed a search warrant upon, a health care provider billing Medicare;
- Provider has been indicted by a Federal Grand Jury for fraud, theft, embezzlement, breach of fiduciary responsibility, or other misconduct related to a health care program;
- Provider presents a pattern of evidence of known false documentation or statements sent to the *UPIC* or the MAC; e.g., false treatment plans, false statements on provider application forms.

D. Good Cause Exceptions

Reference is made in 42 CFR §405.371(b)(1) that allows for good cause exceptions to not suspend payments or continue a payment suspension when there are credible allegations of fraud. These exceptions may be considered for approval by CMS if any apply:

- Law enforcement has requested that a payment suspension not be imposed because such action may compromise or jeopardize its investigation;

- CMS/CPI has determined that a beneficiary access to care issue may exist and potentially cause a danger to life or health in whole or part;

- CMS/CPI has been determined that other administrative remedies may be implemented that would be more effective in protecting Medicare funds (such as revocation, prepayment review); or

- CMS determines that the imposition or the continuation of a payment suspension is not in the best interest of the Medicare program.

Every 180 calendar days after the initiation of a payment suspension based on credible allegations of fraud, CMS is required to evaluate whether there is good cause to terminate the payment suspension. Good cause to terminate a payment suspension is deemed to exist if the payment suspension has been in effect for 18 months. However, there are two exceptions. The first exception is that the case has been referred to and is being considered by the OIG for an administrative action such as a civil monetary penalty or permissive exclusion, or such administrative action is pending, and the OIG has made its request to not terminate the payment suspension in writing. The second exception is that the Department of Justice has submitted a written request to extend the payment suspension based on the ongoing investigation and its anticipation of filing a criminal or civil action or both, or based on a pending criminal or civil action or both. (See 42 CFR §405.371(b)(2) and §405.371(b)(3).)

CMS/CPI makes the final decision on whether good cause to terminate exists, based on the totality of the circumstances. For all fraud suspensions, the *UPICs* shall submit requests to CPI via the FID within 14 calendar days before the suspension expires. CPI will evaluate the request to consider whether good cause to terminate the payment suspension exists.

8.3.1.2 - Reliable Information that an Overpayment Exists – General Suspensions

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

A payment suspension may be implemented when the MAC, *UPIC*, or CMS possesses reliable information that an overpayment exists. In this situation, the MAC shall refer its information to the respective *UPIC* for development of a potential suspension. The *UPIC* shall refer a payment suspension to CPI via the FID for consideration. For the purposes of this section, these types of payment suspensions will be called “general suspensions.”

EXAMPLE (including but not limited to): Several claimed services identified from either a prepayment or post-payment review were determined to be non-covered or miscoded. It has been determined that there is a pattern of noncompliant billings (the provider has billed this service many times before) and it is suspected that there may be a substantial number of additional non-covered or miscoded claims paid in the past.

8.3.1.3 - Reliable Information that the Payments to Be Made May Not Be Correct - General Suspensions

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

A payment suspension may be implemented when the MAC or *UPIC* or CMS possesses reliable information that the payments to be made may not be correct. In this situation, the MAC shall refer its information to the respective *UPIC* for development of a potential suspension. The *UPIC* shall refer a payment suspension to CPI for consideration. For the purposes of this section, these types of payment suspensions will be called "general suspensions."

EXAMPLE (including but not limited to): Several claimed services identified from a post-payment review were determined to be non-covered or miscoded. It has been determined that the provider has not changed its billing behavior and it is suspected that there may be a continuance of non-covered or miscoded claimed services to be billed in the future.

8.3.1.4 - Provider Fails to Furnish Records and Other Requested Information - General Suspensions

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

A payment suspension may be used when the MAC, *UPIC*, or CMS possesses reliable information that the provider has failed to furnish records and other information requested or that is due, and which is needed to determine the amounts due the provider. In this situation, the MAC shall refer its information to the respective *UPIC* for development of a potential suspension. The *UPIC* shall refer a payment suspension to the CPI for consideration. For the purposes of this section, these types of payment suspensions will be called "general suspensions."

EXAMPLE (including but not limited to): During a post-payment review, medical records and other supporting documentation are solicited from the provider to support payment. The provider fails to submit the requested records after two attempts. The *UPIC* may request a payment suspension due to non-response from the provider.

In lieu of imposing a payment suspension, the MAC or *UPIC* may deny the paid claims because the provider failed to provide the requested documentation after two attempts. In either case, the MAC or *UPIC* should determine if the provider is continuing to submit claims for the services in question and take appropriate action(s) to correct the behavior.

NOTE: In the above example, if the only reason for the payment suspension is the failure by the provider to furnish the requested records, and if the provider does eventually provide the requested information, the *UPIC* shall discuss this matter with CPI for guidance.

EXAMPLE (including but not limited to): The provider fails to timely file an acceptable cost report. Refer to 42 CFR §405.371(d). (NOTE: Such requests regarding the timely filing of an acceptable cost report shall be submitted only to and approved by the CMS, Office of Financial Management and not CPI.)

8.3.2.2 - The Notices Involving Payment Suspensions

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

The *UPICs* shall use the following exhibits in this manual as the model notices when preparing the draft notices for CMS approval:

- The Notice to Suspend Payments (Refer to Exhibits 16A to 16D)
- The Notice to Extend the Payment Suspension (Refer to Exhibit 16E) The Notice to Terminate the Payment Suspension (Refer to Exhibit 16F)

8.3.2.2.1 - Issuing a Prior Notice versus Issuing a Concurrent Notice

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

UPICs shall inform the provider of the payment suspension action being taken. When prior notice is appropriate, the *UPIC* shall, in most instances, give at least 15 calendar days' prior notice before effectuating the payment suspension. Day one begins the calendar day after the notice is mailed.

A. If the Medicare Trust Fund would be harmed by giving prior notice: the *UPIC* shall recommend to CPI not to give prior notice if, in the *UPIC's* opinion, any of the following apply:

1. A delay in implementing the payment suspension will cause the overpayment to rise at an accelerated rate (i.e., dumping of claims);

2. There is reason to believe that the provider may flee the MAC's jurisdiction before the overpayment can be recovered;

3. The MAC or *UPIC* has first-hand knowledge of a risk that the provider will cease or severely curtail operations or otherwise seriously jeopardize its ability to repay its debts; or

4. A delay may impact law enforcement's investigation.

If CPI approves waiver of the prior notice requirement, the *UPIC* shall send the provider notice concurrent with implementation of the payment suspension, but no later than 5 calendar days after the payment suspension is imposed. If additional time is needed to release the notice, the *UPIC* shall confer with CPI for guidance.

B. If the reason for the payment suspension request is because the provider failed to furnish requested information, the *UPIC* shall recommend that CPI waive the prior notice. If CPI concurs to waive the prior notice requirement, the *UPIC* shall send the provider notice concurrent with implementation of the payment suspension, but no later than 5 calendar days after the payment suspension is imposed. If additional time is needed to release the notice, the *UPIC* shall confer with CPI for guidance.

C. If the payment suspension request is a fraud suspension, the *UPIC* shall recommend to CPI that prior notice not be given. If CPI concurs to waive the prior notice requirement, the *UPIC* shall send the provider notice concurrent with implementation of the payment suspension, but no later than five calendar days after the payment suspension is imposed. If additional time is needed to release the notice, the *UPIC* shall confer with CPI for guidance.

8.3.2.2.2 - Content of Payment Suspension Notice

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

The *UPIC* shall prepare a "draft notice" (in accordance with section 8.3.2.2 of this chapter) and send it, along with the recommendation and any other supportive information, to CPI for approval. The draft notice shall include, at a minimum:

- The date the payment suspension action will be or has been imposed;

- How long the suspension is expected to be in effect (**NOTE**: All payment suspensions shall

be established in 180 calendar day increments.);

- The reason for suspending payment. (For fraud suspensions, the *UPIC* shall include the rationale to justify the action being taken.);

- In most notices, the *UPIC* shall identify and describe at least five example claims that are associated with the reason for the payment suspension, if available. The claim examples are to be the most current claims available unless otherwise directed by CMS. The notice shall only reference the example claim control number, the amount of payment, and the date of service;

- The extent of the payment suspension (i.e., 100 percent payment suspension or partial payment suspension, where less than 100 percent of payments are withheld);

- The payment suspension action is not appealable;

- CMS/CPI has approved implementation of the payment suspension;

- Documentation that the provider has been given the opportunity to submit a rebuttal statement within 15 calendar days of notification; and

- An address for the provider to mail the rebuttal.

8.3.2.2.3 - Shortening the Notice Period for Cause

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

At any time, the *UPIC* may recommend to CPI that the prior notice be shortened during a previously approved notice period. Such a recommendation would be appropriate if the MAC or *UPIC* believes that the provider will intentionally submit additional claims prior to the effective date of the payment suspension. If CPI approves that the payment suspension is to be imposed earlier than indicated in the issued notice, the *UPIC* shall notify the provider in writing of the change and the reason. The *UPIC* shall draft a notice for CPI's approval before releasing the notice to the provider.

8.3.2.2.4 - Mailing the Notice to the Provider

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

After consultation with and approval from CPI, the *UPIC* shall send the approved payment suspension notice (initial, responses to rebuttals, extensions, and terminations) to the provider. All such notices shall be sent via USPS certified mail or utilizing other commercial mail carriers that allow the tracking of the correspondence to ensure receipt by the provider. In the case of fraud suspensions, the *UPIC* shall send an informational copy to the OIG, FBI, or the AUSA for its file, if law enforcement has been previously involved and/or has an active investigation/case on the provider. The *UPIC* shall also upload the signed copies of all notices released to the provider into the FID.

8.3.2.2.5 - Opportunity for Rebuttal

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

If the payment suspension is approved with prior notice, the provider is afforded an opportunity to submit to the *UPIC* a statement within 15 calendar days indicating why the payment suspension action should not be imposed. However, this time may be shortened or lengthened for

cause. (See 42 CFR §405.374(b).)

If the payment suspension is approved without prior notice, the provider is also afforded an opportunity to submit to the *UPIC* a statement as to why the payment suspension action should not be imposed. (See 42 CFR §405.372(b)(2).) For purposes of consistency for both prior notice and no prior notice, CMS/CPI suggests that a 15 calendar day response time be established for the provider.

If a provider submits a rebuttal timely, a timely determination and written response by the *UPIC* is required in accordance with 42 CFR §405.375. If a provider does not respond in a timely manner, the *UPIC* shall submit a written response to the provider within 30 calendar days from the receipt date of the rebuttal.

UPICs shall ensure the following:

- CMS Review – *UPICs* shall forward the provider's rebuttal statement and any pertinent information to CPI via the FID within 1 business day of receipt. The *UPIC* shall evaluate the information presented and then draft a response addressing each item mentioned in the rebuttal and submit it to CPI for approval via the FID no later than 10 calendar days from receipt. The *UPIC* may contact CPI for guidance before drafting a response.

- Timing –The payment suspension shall go into effect as indicated in the notice.

- Review of Rebuttal – Because payment suspension actions are not appealable, the rebuttal is the provider's only opportunity to present information as to why suspension action should not be initiated or should be terminated. *UPICs* shall carefully review the provider's rebuttal statement and pertinent information, and shall consider all facts and issues raised by the provider. If the *UPIC* is convinced that the payment suspension action should not be initiated or should be terminated, it shall consult with the CPI for guidance.

- Response – CMS is obligated to consider the initial rebuttal and supportive information received from the provider and to make a determination within 15 calendar days from receipt of the rebuttal. (See 42 CFR §405.375(a).) If a full response cannot be drafted in the required timeframe, the *UPIC* shall draft an interim response for release that is approved by CPI.

8.3.2.3.1 - Claims Review

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

While a payment suspension does not stop claims processing, CMS prefers that all claims being processed during the payment suspension period be reviewed on a prepayment basis for reasonableness and necessity. If fraud-related, the review of claims should also address whether services were actually rendered as billed. This will ensure that the withheld payments only include payable claims to be used in the disposition of the funds when the final overpayment(s) are determined.

A. Claims Review

Once a payment suspension has been imposed, the MACs and *UPICs* shall follow the claims processing and review procedures in accordance with Pub. 100-08, chapter 3. MACs and *UPICs* shall ensure that the provider is not substituting a new category of improper billings to counteract the effect of the payment suspension. (If such a situation arises, the *UPIC* shall modify the payment suspension accordingly with CPI's approval.) If the claim is determined to not be

payable, it shall be denied and the provider afforded its appeal rights. For claims that are not denied, the MAC shall send a remittance advice to the provider showing that payment was approved but the actual funds not sent.

UPICs are not required to perform 100 percent prepayment review of claims processed during the payment suspension period. If prepayment review is not conducted, a post- payment review shall be performed on the universe of claims adjudicated for payment during the payment suspension, prior to the issuance of the overpayment determination. In order to reduce the burden of resources, if only specific claim types (or certain codes) are the subject of noncompliance, the *UPIC* may elect to only place such claims types on prepayment or post-payment review. *UPICs* shall consult with CPI for guidance when resources may be better utilized employing statistical sampling for overpayment determination(s). *UPICs* shall use the principles of statistical sampling for overpayment estimation found in section 8.4 of this chapter to determine what percentage of claims in a given universe of withheld claims payments are payable. In all cases involving a post- payment review, the *UPIC* shall follow the rules of reopening as defined in 42 C.F.R. §405.980 and inform the provider that the claims are reopened in accordance with the regulations when requesting records and supportive information.

B. Review of Suspected Fraudulent or Overpaid Claims:

The *UPIC* shall follow procedures in Pub. 100-08, chapter 3, section 3.6 in establishing an overpayment. The overpayment consists of all claims in a specific time period(s) determined to have been paid incorrectly. The *UPIC* shall make all reasonable efforts to expedite the determination of the overpayment amount. The *UPIC* shall account for binding revised determinations or binding reconsiderations in its overpayment determination in accordance with 42 CFR §405.984.

NOTE: Claims selected for post-payment review may be reopened within one year for any reason or within four years for good cause. (See 42 CFR §405.980.) Cost report determinations may be reopened within three years after the Notice of Program Reimbursement has been issued. Good cause is defined as new and material evidence, error on the face of the record, or clerical error. The regulations have open-ended potential for fraud or similar fault. The exception to the one-year rule is for adjustments to DRG claims. A provider has 60 calendar days to request a change in an assignment of a DRG. (See 42 C.F.R. §412.60(d).)

8.3.2.3.2 - Case Development – Program Integrity

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

The *UPIC* shall enter all payment suspensions into the FID. In the Suspension Narrative field, the *UPIC* shall include the items/services affected (i.e., type of item/service and applicable HCPCS/CPT codes). The first monetary entry of money withheld in the FID shall reflect the money withheld on Day One of the payment suspension.

8.3.2.4 - Duration of the Payment Suspension

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

A. Time Limits for General Suspensions

If CPI approves a general suspension, it will be for a 180 calendar day period. The *UPIC* shall complete its medical review and any subsequent activities (i.e., statistical sampling extrapolation, draft overpayment determination notice, etc.) during the initial 180 days of a general suspension.

CMS expects the medical reviews to be completed and the calculation of any potential overpayments to be determined before the end of the initial suspension period. Only in rare instances will an extension be granted.

If an extension is required, the *UPIC* shall request an extension of an additional 180 calendar days if time is needed to complete the overpayment determination. Only CPI may approve the request to extend the period of the payment suspension for up to an additional 180 calendar days upon the written request of the *UPIC*. The request to CPI to extend the payment suspension shall provide the following:

- The AAR – Payment Suspension form
- A draft of the proposed payment suspension extension notice following the format noted in section 8.3.2.2 of this chapter (in a word document format);
- A timeline of the completion of the medical review; and
- Any other supporting documentation.

If approved for an extension, the period of time shall not exceed 180 calendar days. General suspensions shall not continue beyond 360 calendar days. However, there may be an occasion when the information gathered by the *UPIC* during its review supports a change from a general suspension to a fraud suspension. Only with CPI approval may the category of the type of payment suspension be transitioned from a general payment suspension to a fraud suspension. If the transition from a general payment suspension to a fraud payment suspension is approved, the provider must be informed of the new development by the *UPIC* with a CPI-approved notice. Additionally, the provider must be afforded the opportunity for rebuttal.

B. Exceptions to Time Limits for Fraud Suspensions

If a payment suspension is based on credible allegations of fraud, the payment suspension may continue beyond 360 days with a written request for an extension from law enforcement. An extension may be warranted if there has not been a resolution of law enforcement's investigation of the potential fraud. After 18 months, good cause not to continue a payment suspension is deemed to exist unless certain criteria are satisfied. (See 42 C.F.R. §405.371(b)(3).) To extend a fraud suspension beyond 18 months:

- The Department of Justice must submit a written request for an extension. Requests must include: 1) the identity of the person or entity under the payment suspension, 2) the amount of time needed for continuation of the payment suspension in order to conclude the criminal or civil proceeding or both, and 3) a statement of why and/or how criminal and/or civil actions may be affected if the payment suspension is not granted.

- The OIG must submit a written request to extend the payment suspension because the case is being considered by the OIG for an administrative action (e.g., permissive exclusions, CMPs) or such action is pending. However, this exception does not apply to pending criminal investigations by OIG.

C. Provider Notice of the Extension

The *UPIC* shall obtain CPI approval for the extension request and draft notice, and shall notify the provider if the suspension action has been extended. The *UPIC* shall prepare a "draft extension notice" (in accordance with section 8.3.2.2 of this chapter) and submit it via the FID, along with any other supportive information, to CPI for approval at least 14 calendar days before the payment suspension is set to expire. The draft notice shall follow the model language

provided in the exhibits and shall include, at a minimum:

- The date the payment suspension will be extended (**NOTE**: The date is to be the same date the payment suspension was to expire);

- The reason for extending the payment suspension; and

- That CMS has approved the extension of the payment suspension.

Upon approval of the notice from CPI, the *UPIC* shall provide a copy of the signed notice to CPI via the FID.

8.3.2.5 - Terminating the Payment Suspension

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

The *UPIC* shall recommend to CPI that the payment suspension be terminated prior to the payment suspension expiring. The *UPIC* shall provide this request via the FID at least 14 calendar days prior to the anticipated payment suspension expiration date. No action associated with the termination shall be taken without the explicit approval of CPI. The *UPIC* shall prepare a "draft termination notice" (in accordance with section 8.3.2.2 of this chapter) and send it, along with a draft overpayment notice(s) and any other supportive information, to CPI for approval.

The *UPIC* shall recommend to CPI that a suspension be terminated when any of the following occur:

- The basis for the payment suspension action was that an overpayment may exist or money to be paid may be incorrect, and the *UPIC* has determined the amount of the overpayment, if any.

- The basis for the payment suspension action was that a credible allegation of fraud exists against the provider, and the amount of the overpayment has been determined.

- The basis for the payment suspension action was that payments to be made may not be correct, and the *UPIC* has determined that current payments to be made are now correct, and any associated overpayments have been determined.

- The basis for the payment suspension action was that the provider failed to furnish records, and the provider has now submitted all appropriate requested records.

When the payment suspension is terminated, the disposition of the withheld funds shall be achieved in accordance with 42 CFR §405.372(e) and the payment suspension edit withholding the provider's funds is removed in the MAC system accordingly. Upon approval of the termination notice by CPI, the *UPIC* shall provide a copy of the signed notice via the FID to CPI.

8.3.2.6 - Disposition of the Withheld Funds

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

The MAC and *UPIC* shall maintain an accurate, up-to-date record of the dollar amount withheld and the claims that comprise the withheld amount. The MAC and *UPIC* shall keep a separate accounting of payment on all claims affected by the payment suspension. They shall keep track of how much money is uncontested and due the provider. The amount needs to be known as it represents assets that may be applied to reduce or eliminate any overpayment. (See section 8.2 of

this chapter.) The MAC and *UPIC* shall be able to provide, upon request, copies of the claims affected by the payment suspension. The MAC shall coordinate the issuance of the demand for the overpayment(s) and termination of the payment suspension with respect to approved action by CPI. The MAC shall apply the amount withheld first to the Medicare overpayment(s) and then apply any excess money to reduce any other obligation to CMS or to DHHS, unless otherwise directed by CMS. The MAC shall remit to the provider all monies held in excess of the amount the provider owes. If the provider owes more money than what was withheld as a result of the payment suspension, the MAC shall initiate recoupment action, unless otherwise directed by CMS. See 42 CFR §405.372(e).

8.3.2.7 - Contractor Suspects Additional Improper Claims

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

A. Present Time

If the payment suspension is in the process of being terminated or has been terminated, and the *UPIC* believes that the provider will continue to submit noncovered, misrepresented, or potentially fraudulent claims, the *UPIC* shall consider implementing or recommending other actions as appropriate (e.g., education, prepayment review, revocation, a new suspension of payment.)

B. Past Period of Time

If the payment suspension is in the process of being terminated or has been terminated, and the *UPIC* believes there are past periods of claims submissions that may contain possible overpayments, the *UPIC* shall consider recommending a new payment suspension covering those dates.

C. Additional Services

If, during the time that a provider is under a partial payment suspension for a particular service(s), the *UPIC* determines there is reason to initiate a payment suspension action for a different service, a new payment suspension shall be initiated or the new service(s) shall be incorporated into the existing payment suspension depending on the circumstances. The *UPIC* shall discuss this action with CPI for a decision.

Any time a new suspension action is initiated on a provider who is already under one or more partial payment suspension actions, the *UPIC* shall, if appropriate: (1) obtain separate CMS approval, (2) issue an additional notice to the provider, and (3) offer a new rebuttal period to the provider.

8.3.3.1 - DME Payment Suspensions (MACs and *UPICs*)

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

For national payment suspensions involving durable medical equipment (DME) suppliers that are enrolled in multiple jurisdictions, the following is applicable for DME MACs and *UPICs*:

- When CMS suspends payments to a DME supplier, all payments to the supplier are suspended in all DME jurisdictions if the same Tax Identification Number is used. The information (whether based on fraud or non-fraud) that payments
should be suspended in one DME jurisdiction is sufficient reason for payment suspension

decisions to apply to the other locations.

- The *UPIC* that requests the national payment suspension to CPI shall become the "lead" contractor for the payment suspension if the payment suspension is approved. The lead contractor is responsible for informing the other respective contractors of the payment suspension being initiated and for the coordination of the payment suspension activities. CMS suggests that monthly contractor calls be held to communicate the current activities of the national suspension by each of the contractors.

- The lead is responsible for coordinating and reporting to its CORs and BFLs whether the other contractors are compliant with the payment suspension timeframe and activities.

- All non-lead contractors are also responsible for determining an overpayment(s) for its jurisdiction. Non-lead contractors shall take into account the findings of the lead contractor and take appropriate measures (prepayment review, etc.) to protect and safeguard Medicare Trust Fund dollars from being inappropriately paid.

For *UPIC*-initiated DME payment suspensions:

- Each *UPIC* shall be responsible for ensuring that the payment suspension edit has been initiated in its respective DME MAC jurisdiction and has communicated this to the lead *UPIC*.

Each *UPIC* shall be responsible for providing timely updates on the withheld money in its corresponding DME MAC jurisdiction to the lead *UPIC* for input in the FID payment suspension module, and in accordance with the FID requirements.

8.3.3.2 - Non-DME National Payment Suspensions (MACs and *UPICs*)

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

For national payment suspensions involving national providers (such as chain hospitals, chain Skilled Nursing Facilities, franchised clinics, laboratories, etc.) that are enrolled in multiple jurisdictions, the following may be applicable for MACs and *UPICs*:

- When CMS suspends payments to a national provider, all payments to the national provider are suspended in all jurisdictions if they share the same Tax Identification Number. The information (whether based on fraud or non-fraud) that payments should be suspended in one jurisdiction is sufficient reason for payment suspension decisions to apply to the other locations. The *UPIC* that requests the national payment suspension to CPI shall become the "lead" contractor for the payment suspension. The lead contractor is responsible for informing the other respective contractors of the payment suspension being initiated and for the coordination regarding the payment suspension activities. CMS suggests that monthly contractor calls be held to communicate the current activities by each of the contractors.

- The lead is responsible for coordinating and reporting to its CORs and BFLs whether the other contractors are compliant with the payment suspension timeframe and activities.

- All non-lead contractors shall be responsible for determining an overpayment(s) for its jurisdiction. Non-lead contractors shall take into account the findings of the lead contractor and take appropriate measures (prepayment review, etc.) to protect and safeguard Medicare Trust Fund dollars from being inappropriately paid.

For *UPIC*-initiated non-DME national payment suspensions:

- Each *UPIC* shall be responsible for ensuring that the payment suspension edit has been initiated in its respective MAC jurisdiction and has communicated this to the lead *UPIC*.

Each *UPIC* shall be responsible for providing timely updates on the withheld money in its respective zone to the Lead *UPIC*, so it can update the FID payment suspension module in accordance with the FID requirements.

Medicare Program Integrity Manual

Chapter 10 – Medicare Enrollment

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10.2.5 – Suppliers That Enroll Via the Form CMS-855S

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

A. Suppliers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)

1. Special Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Instructions

Sections 10.2.5(A)(1) through 10.2.5(A)(2) instruct the National Supplier Clearinghouse on the appropriate handling of certain situations involving DMEPOS suppliers.

2. DMEPOS Supplier Accreditation

a. General Requirement

DMEPOS suppliers must be accredited prior to submitting an application to the National Supplier Clearinghouse (NSC). The NSC shall deny any DMEPOS supplier's enrollment application if the enrollment package does not contain an approved accreditation upon receipt.

The NSC shall revoke an enrolled DMEPOS supplier’s billing privileges if the DMEPOS supplier fails to: (1) obtain and submit supporting documentation that the DMEPOS supplier has been accredited, or (2) maintain its required accreditation.

In the future, Medicare will deny claims for those DMEPOS suppliers who fail to maintain accreditation information on file with the NSC.

b. Exemptions

Individual medical practitioners, inclusive of group practices of same, do not require accreditation as a condition of enrollment. The practitioner types are those specifically stated in Sections 1848(K)(3)(B) and 1842(b)(18)(C) of the Social Security Act. In addition, the practitioner categories of physicians, orthotists, prosthetists, optometrists, opticians, audiologists, occupational therapists, physical therapists and suppliers who provide drugs and pharmaceuticals (only) do not require accreditation as a condition of enrollment.

Although suppliers that provide only drugs and pharmaceuticals are exempt from the accreditation requirement, suppliers that provide equipment to administer drugs or pharmaceuticals must be accredited.

c. Special Situations

Changes of Ownership

i. Change of Ownership and Accreditation

A change of ownership application for an existing supplier location submitted by a new owner company with a new tax identification number (TIN) shall be denied (consistent with 42 CFR § 424.57) if the new owner does not have an accreditation that covers all of its locations. If the old owner has such an accreditation, the new owner can be enrolled as of the date of sale if the accreditor determines that the accreditation should remain in effect as of the date of sale. (This,

however, is only applicable when the new owner also meets all other enrollment criteria found at 42 CFR §424.57).

ii. Change of Ownership Involving More than 5 Percent of the Ownership Interest

Some ownership changes do not result in a complete change of ownership, since the business entity remains the same with no change in TIN. However, in cases where more than 5 percent of the ownership has changed, the following principles apply:

- If the change in ownership has not been reported to the NSC within the required 30-day period, the NSC shall proceed with revocation action.

- If the change has been received within the required 30-day period and the supplier has been accredited, the NSC shall immediately notify the accreditor of the ownership change and request that the latter advise the NSC if the accreditation should still remain in effect.

iii. Accreditation and Deactivation/Revocation

A non-exempt DMEPOS supplier requesting reactivation after a deactivation (regardless of the deactivation reason) is required to be accredited.

A revoked DMEPOS supplier that has submitted an acceptable corrective action plan can be reinstated without accreditation unless the accreditation was already required prior to revocation.

d. Fraud Level Indicators for DMEPOS Suppliers - Development and Use

The National Supplier Clearinghouse (NSC) shall perform a fraud potential analysis of all DMEPOS applicants and current DMEPOS suppliers. The fraud level indicator shall represent the potential for fraud and/or abuse. The NSC shall use four fraud level indicator codes as follows:

- Low Risk (e.g., national drug store chains)

- Limited Risk (e.g., prosthetist in a low fraud area)

- Medium Risk (e.g., midsize general medical supplier in a high fraud area)

- High Risk (e.g., very small space diabetic supplier with low inventory in a high fraud area whose owner has previously had a chapter 7 bankruptcy).

High fraud areas shall be determined by contractor analysis with concurrence of the NSC project officer.

(**NOTE:** These risk categories are in addition to, and not in lieu of, those specified in section 15.19.2 of Pub. 100-08, Chapter 15.)

In assessing a fraud level indicator, the NSC shall consider such factors as:

- Experience as a DMEPOS supplier with other payers

- Prior Medicare experience
- The geographic area
- Fraud potential of products and services listed
- Site visit results
- Inventory observed and contracted
- Accreditation of the supplier

After a fraud level indicator is assigned and the DMEPOS supplier is enrolled, the NSC shall establish a DMEPOS Review Plan based on the fraud level assessment. The DMEPOS Review Plan shall contain information regarding:

- Frequency of unscheduled site visits
- Maximum billing amounts before recommendation for prepay medical review
- Maximum billing spike amounts before recommendation for payment suspensions/prepay medical review, etc.

The fraud level indicator shall be updated based upon information obtained through the Medicare enrollment process, such as reported changes of information.

Information obtained by the Office of Inspector General (OIG), CMS (including CMS satellite office) and/or a Unified Program integrity Contractor (UPIC) shall be reported to the NSC project officer. The NSC shall update the fraud level indicator based on information obtained by the OIG, CMS (including CMS satellite office) and/or a UPIC only after the review and concurrence of the NSC project officer.

In addition, the NSC shall monitor and assess geographic trends which indicate or demonstrate that one geographic area has a higher potential for having fraudulent suppliers.

e. A DMEPOS Fraud Level Indicator Differs From Risk Screening Category under 42 CFR §424.518

The fraud level indicator described in this subsection is unrelated to the risk screening categories required under 42 CFR §424.518. Under §424.518(c)(1)(ii), for example, newly enrolling DMEPOS suppliers are assigned to the "high" risk screening category. Such DMEPOS suppliers are therefore subject to screening activities that correspond to the "high" risk screening category, including, and not limited to an on-site visit and a fingerprint-based criminal background check for all individuals who maintain a 5 percent or greater direct or indirect ownership interest in the supplier §424.518(c)(2). The on-site visits that the NSC conducts are responsive to the requirement at §424.518(c)(2)(i) for a site visit and include gathering information concerning fraud level indicator assignment as required in this subsection. A DMEPOS supplier therefore has both a risk based screening category assignment pursuant to requirements under §424.518, and a separate fraud level indicator based upon the guidance in this subsection.

f. Fraud Level Indicator Standards

The NSC shall have documented evidence that it has, at a minimum, met the following requirements:

- Assign an appropriate fraud level indicator for at least 95 percent of all DMEPOS suppliers, upon initial enrollment or revalidation. The fraud level indicator shall accurately reflect the risk the supplier poses to the Medicare program based on pre-defined criteria above.

- Update the DMEPOS fraud level indicator for each enrolled DMEPOS supplier on an annual basis.

g. Alert Codes for DME Suppliers

The NSC shall receive and maintain the following "alert indicators" from the DME MACs and Unified Program Integrity Contractors (UPICs):

Alert Code	Definition
A	Possible fraudulent or abusive claims identified
B	Overpayments
D	Violations of disclosure of ownership requirements
E	Violations of participation agreements
L	Suspended by contractor outside alert code process
M	Supplier is going through claims appeal process

The NSC shall append the supplier file and transfer to the DME-MACs and/or UPICs the following alert codes in the following circumstances:

Alert Code	Definition
C	Violations of supplier standards
F	Excluded by the Office of Inspector General or debarred per the GSA debarment list
H	Meets supplier standards; however, the NSC recommends increased scrutiny by the contractor (initiated by NSC-MAC only)
N	Supplier being investigated under the "Do Not Forward" initiative (initiated by NSC only)
Q	Low Risk Fraud Level Indicator
R	Limited Risk Fraud Level Indicator
S	Medium Risk Fraud Level Indicator

The NSC shall append an Alert Code "H" for any supplier that meets present supplier standards but appears suspect in one of the areas that are verified by the NSC. This alert code notifies the contractors that a supplier may be inclined to submit a high percentage of questionable claims.

The NSC shall share the above information with the DME MACs and/or UPICs by sending alerts within 7 calendar days after identification of a supplier having common ownership or business ties with a sanctioned or suspect supplier for their research and/or action. The NSC also shall forward alert codes submitted by the contractors with the other contractors within 7 calendar days after receipt.

3. Surety Bonds

a. Background

Surety Bond Exemptions

All DMEPOS suppliers are subject to the surety bond requirement, except:

- Government-operated DMEPOS suppliers are exempted if the supplier has provided CMS with a comparable surety bond under State law.

- State-licensed orthotic and prosthetic personnel (which, for purposes of the surety bond requirement, does not include pedorthists) in private practice making custom- made orthotics and prosthetics are exempted if—

  - The business is solely-owned and operated by the orthotic and prosthetic personnel, and

  - The business is only billing for orthotic, prosthetics, and supplies.

- Physicians and non-physician practitioners, as defined in section 1842(b)(18) of the Social Security Act, are exempted if the items are furnished only to the physician or non-physician practitioner’s own patients as part of his or her physician service. The non-physicians covered under this exception are: physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives, clinical social workers, clinical psychologists, and registered dietitians or nutrition professionals.

- Physical and occupational therapists in private practice are exempted if—

  - The business is solely-owned and operated by the physical or occupational therapist;

  - The items are furnished only to the physical or occupational therapist’s own patients as part of his or her professional service; and

  - The business is only billing for orthotics, prosthetics, and supplies.

If a previously-exempted DMEPOS supplier no longer qualifies for an exception, it must submit a surety bond to the NSC - in accordance with the requirements in 42 CFR §424.57 - within 60 days after it knows or has reason to know that it no longer meets the criteria for an exception.

b. Bond Submission

Effective May 4, 2009, DMEPOS suppliers submitting: (1) an initial enrollment application to enroll in the Medicare program for the first time, (2) an initial application to establish a new practice location, or (3) an enrollment application to change the ownership of an existing supplier, are required to obtain and submit a copy of its required surety bond to the NSC with their CMS-855S enrollment application. (**NOTE:** Ownership changes that do not involve a change in the status of the legal entity as evidenced by no change in the tax identification number, or changes that result in the same ownership at the level of individuals (corporate reorganizations and individuals incorporating) are not considered to be "changes of ownership" for purposes of the May 4, 2009, effective date – meaning that such suppliers are considered "existing" suppliers).

For any CMS-855S application submitted on or after May 4, 2009, by a supplier described in this section (2), the NSC shall reject the application if the supplier does not furnish a valid surety bond at the time it submits its application. The rejection shall be done in accordance with existing procedures (e.g., reject application after 30 days).

c. Amount and Basis

The surety bond must be in an amount of not less than $50,000 and is predicated on the NPI, not the tax identification number. Thus, if a supplier has two separately-enrolled DMEPOS locations, each with its own NPI, a $50,000 bond must be obtained for each site.

A supplier may obtain a single bond that encompasses multiple NPIs/locations. For instance, if a supplier has 10 separately-enrolled DMEPOS locations, it may obtain a $500,000 bond that covers all 10 locations.

As stated in 42 CFR §424.57(d)(3), a supplier will be required to maintain an elevated surety bond amount of $50,000 for each final adverse action imposed against it within the 10 years preceding enrollment or reenrollment. This amount is in addition to, and not in lieu of, the base $50,000 amount that must be maintained. Thus, if a supplier has had two adverse actions imposed against it, the bond amount will be $150,000.

- A final adverse action is one of the following:

o A Medicare-imposed revocation of Medicare billing privileges;

o Suspension or revocation of a license to provide health care by any State licensing authority;

o Revocation or suspension by an accreditation organization;

o A conviction of a Federal or State felony offense (as defined in §424.535(a)(3)(i)) within the last 10 years preceding enrollment or re-enrollment; or

o An exclusion or debarment from participation in a Federal or State health care program.

d. Bond Terms

The supplier is required to submit a copy of the bond that - on its face - reflects the requirements of 42 CFR §424.57(d). Specific terms that the bond must contain include:

- A guarantee that the surety will - within 30 days of receiving written notice from CMS containing sufficient evidence to establish the surety's liability under the bond of unpaid claims, civil monetary penalties (CMPs), or assessments - pay CMS a total of up to the full penal amount of the bond in the following amounts:

- The amount of any unpaid claim, plus accrued interest, for which the DMEPOS supplier is responsible, and

- The amount of any unpaid claims, CMPs, or assessments imposed by CMS or the OIG on the DMEPOS supplier, plus accrued interest.

- A statement that the surety is liable for unpaid claims, CMPs, or assessments that occur during the term of the bond.

- A statement that actions under the bond may be brought by CMS or by CMS contractors.

- The surety's name, street address or post office box number, city, State, and zip code.

- Identification of the DMEPOS supplier as the Principal, CMS as the Obligee, and the surety (and its heirs, executors, administrators, successors and assignees, jointly and severally) as the surety.

The term of the initial surety bond must be effective on the date that the application is submitted to the NSC. Moreover, the bond must be continuous.

e. Sureties

The list of sureties from which a bond can be secured is found at Department of the Treasury's "Listing of Certified (Surety Bond) Companies;" the Web site is https://www.fiscal.treasury.gov/fsreports/ref/suretyBnd/c570_a-z.htm. For purposes of the surety bond requirement, these sureties are considered "authorized" sureties, and are therefore the only sureties from which the supplier may obtain a bond.

f. Bond Cancellations and Gaps in Coverage

A DMEPOS supplier may cancel its surety bond, but must provide written notice of such to the NSC and the surety at least 30 days before the effective date of the cancellation. Cancellation of a surety bond is grounds for revocation of the supplier's Medicare billing privileges unless the supplier provides a new bond before the effective date of the cancellation. The liability of the surety continues through the termination effective date.

If a gap in coverage exists, the NSC shall revoke the supplier's billing privileges. If a supplier changes its surety during the term of the bond, the new surety is responsible for any overpayments, CMPs, or assessments incurred by the DMEPOS supplier beginning with the effective date of the new surety bond; the previous surety is responsible for any overpayments, CMPs, or assessments that occurred up to the date of the change of surety.

Pursuant to 42 CFR 424.57(d)(6)(iv), the surety must notify the NSC if there is a lapse in the surety's coverage of the DMEPOS supplier. This can be done via letter, fax, or e-mail to the

NSC; the appropriate addresses can be found on the NSC's Web site at www.palmettogba.com/nsc.

g. Reenrollment and Reactivation

The supplier must furnish the paperwork described in subsection 10.2.5(A)(3)(d) above with any CMS-855S reenrollment or reactivation application it submits to the NSC unless it already has the information on file with the NSC. For example, if a supplier has submitted a continuous surety bond to the NSC prior to submission of its reenrollment application, a new copy of surety bond is not be required unless the NSC specifically requests it.

h. Surety Bond Changes

A DMEPOS supplier must submit an addendum to the existing bond (or, if the supplier prefers, a new bond) to the NSC in the following instances: (1) change in bond terms, (2) change in bond amount, or (3) a location on a bond covering multiple non-chain locations is being added or deleted.

i. Claims against Surety Bonds

Pursuant to 42 CFR §424.57(d)(5)(i), the surety must pay CMS - within 30 days of receiving written notice to do so - the following amounts up to the full penal sum of the bond:

i. The amount of any unpaid claim, plus accrued interest, for which the supplier of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) is responsible.

ii. The amount of any unpaid claim, civil monetary penalty (CMP) or assessment imposed by CMS or the Office of Inspector General (OIG) on the DMEPOS supplier, plus accrued interest.

This section 10.2.5(A)(3)(i) describes the procedures involved in making a claim against a surety bond.

j. Unpaid Claims

Background

For purposes of the surety bond requirement, 42 CFR §424.57(a) defines an "unpaid claim" as an overpayment (including accrued interest, as applicable) made by the Medicare program to the DMEPOS supplier for which the supplier is responsible.

The policies in this section 10.2.5(A) only apply to overpayment determinations relating to demands first made on or after March 3, 2009. A surety is liable for any overpayments based on dates of service occurring during the term of the surety bond. (For purposes of determining surety liability, the date of the initial demand letter was sent to the provider is the date on which the service was performed/furnished.) Even if the overpayment determination is made after the expiration of the surety bond, the surety remains liable if the date of service was within the surety bond coverage period. In short, the date of service--rather than the date of the overpayment determination or the date the overpayment or demand letter was sent to the supplier---is the principal factor in ascertaining surety liability.

As an illustration, assume that a supplier has a surety bond with Company X on August 1, 2015. It performs a service on October 1, 2015. The supplier ends its coverage with Company X effective January 1, 2016 and obtains a new surety bond with Company Y effective that same date. On February 1, 2016, CMS determines that the October 1, 2015 service resulted in an overpayment; on March 2, 2016, CMS sends an overpayment demand letter to the supplier. While the overpayment determination and the sending of the demand letter occurred during Company Y's coverage period, the date of service was within the Company X coverage period. Thus, liability (and responsibility for payment) rests with Company X, even though the supplier no longer has a surety bond with X.

k. Collection

i. **Delinquency Period**

If the Durable Medical Equipment Medicare Administrative Contractor (DME MAC) determines – in accordance with CMS's existing procedures for making overpayment determinations - that (1) the DMEPOS supplier has an unpaid claim for which it is liable, and (2) no waiver of recovery under the provisions of Section 1870 of the Social Security Act is warranted, the DME MAC shall attempt to recover the overpayment in accordance with the instructions in CMS Pub. 100-06, chapter 4.

If 80 days have passed since the initial demand letter was sent to the DMEPOS supplier and full payment has not been received, the DME MAC shall attempt to recover the overpayment. The DME MAC shall review the "List of Bonded Suppliers" the last week of each month to determine which suppliers that have exceeded this 80-day period have a surety bond. Said list:

- Will be electronically sent to the DME MACs by the Provider Enrollment & Oversight Group on a monthly basis.
- Will be in the form of an Excel spreadsheet.
- Will contain the supplier's legal business name, tax identification number, NPI, surety bond amount and other pertinent information.

If the supplier does not have a surety bond (i.e., is exempt from the surety bond requirement), the DME MAC shall continue to follow the instructions in Pub. 100-06, chapter 4 regarding collection of the overpayment.

ii. **Request for Payment from Surety**

If, however, the supplier has a surety bond (and subject to situations (1) through (6) below), the DME MAC shall send an "Intent to Refer" (ITR) letter to the supplier and a copy thereof to the supplier's surety. The letter ITR and copy shall be sent to the supplier on day 66 after the initial demand letter was sent, and the surety notification shall be sent within 5 days. (The copy to the surety can be sent via mail, e-mail, or fax.)

(NOTE: Under federal law, a delinquent debt must be referred to the Department of Treasury within 120 days. (Per the chart below, this represents Day 150 of the entire collection cycle.) To ensure that the DME MAC meets this 120-day limit yet has sufficient time to prepare the surety letter as described in the following paragraph, it is recommended

that the DME MAC send the ITR letter several days prior to the 90-day limit referenced in the previous paragraph. This will give the DME MAC a few additional days beyond the 30-day deadline referenced in the next paragraph to send the surety letter.)

If the DME MAC does not receive full payment from the supplier within 30 days of sending the ITR letter (and subject to situations (1) through (6) below), the contractor shall notify the surety via letter that in accordance with 42 CFR §424.57(d)(5)(i)(A), the surety must make payment of the claim to CMS within 30 days from the date of the surety letter. (The DME MAC shall send a copy of the surety letter to the supplier on the same date.) The DME MAC shall send the surety letter no later than 30 days after sending the ITR letter (subject to the previous paragraph), depending on the facts of the case. Consider the following situations:

1. If a DMEPOS supplier has withdrawn from Medicare or has had its enrollment deactivated or revoked, the contractor shall send the ITR and the surety letter on the earliest possible day.

2. If the supplier has an extended repayment schedule (ERS) and is currently making payments, the DME MAC shall not send an ITR letter or a surety letter. If the DME MAC is currently reviewing an ERS application from the supplier, the contractor shall delay sending the ITR letter and the surety letter until after the ERS review is complete.

3. If the aggregated principal balance of the debt is less than $25, the DME MAC shall not send an ITR letter or a surety letter. It shall instead follow the instructions in CMS Pub. 100-06, chapter 4 regarding collection of the overpayment.

4. If the DME MAC believes the debt will be collected through recoupment, it shall not send an ITR letter or a surety letter. It shall instead follow the instructions in Pub. 100-06, chapter 4 regarding collection of the overpayment.

5. If the supplier has had a recent offset, the DME MAC may wait to see if future offsets will close the debt, without sending the surety a letter. If the debt is still not paid in full or an ERS has not been established, the DME MAC shall send the surety letter no later than the 115th day after the initial demand letter was sent.

l. A payment demand letter shall not be sent to the surety if the DME MAC is certain that the $50,000 surety bond amount in question has been completely exhausted.

The DME MAC may choose to aggregate debts from the same supplier into one surety letter, provided they are at least 30 days delinquent.

The surety letter shall:

- Follow the format of the applicable model letter in Section 10.7.15 through 10.7.15(E).

- Identify the specific amount to be paid and be accompanied by “sufficient evidence” of the unpaid claim. “Sufficient evidence” is defined in 42 CFR §424.57(a) as documents that CMS may supply to the DMEPOS supplier’s surety to establish that the supplier had received Medicare funds in excess of the amount due and payable under the statute and regulations.

- Be accompanied by the following documents, which constitute "sufficient evidence" for purposes of §424.57(a):

m. Overpayment Services Report

A computer-generated "Overpayment Services Report" containing the following information:

i. Date of service (i.e., the date the service was furnished/performed, not the date of the overpayment determination or the date of the overpayment or demand letter)
ii. Date on which supplier was paid
iii. Paid Amount
iv. Overpayment Amount

(NOTE: The report shall not include HICN, or any information otherwise protected under the Privacy Act.)

n. Overpayment Determination Letter

A copy of the overpayment determination letter that was sent to the supplier.

- State that payment shall be made via check or money order and that the Payee shall be the DME MAC.

- Identify the address to which payment shall be sent.

The DME MAC shall only seek repayment up to the full penal sum amount of the surety bond. Thus, if the supplier has a $60,000 unpaid claim and the amount of the supplier's bond coverage is $50,000, the DME MAC shall only seek the $50,000 amount. The remaining $10,000 will have to be obtained from the supplier via the existing overpayment collection process.

Follow-Up Contact

Between 8 and 12 calendar days after sending the surety letter, the DME MAC shall contact the surety by telephone or e-mail to determine whether the surety received the letter and, if it did, whether and when payment will be forthcoming.

If the surety indicates that it did not receive the letter, the DME MAC shall immediately fax or e-mail a copy of the letter to the surety. The surety will have 30 days from the original date of the letter – not 30 days from the date the letter was resent to the surety – to submit payment. To illustrate, suppose the DME MAC on April 1 sends the surety letter, which is also dated April 1. It places the follow-up call to the surety on April 11. The surety states that it never received the letter, so the contractor e-mails a copy of it to the surety that same day. Payment must be received by May 1, or 30 days from the original date of the letter.

If the surety cannot be reached (including situations where a voicemail message must be left) or if the surety indicates that it did receive the letter and that payment is forthcoming, no further action by the contractor is required. If the surety indicates that payment is not forthcoming, the contractor shall (1) attempt to ascertain the reason, and (2) follow the steps outlined in section 10.2.5(A)(3)(o)(ii) below after the 30-day period expires.

The contractor shall document any attempts to contact the surety by telephone and the content of any resultant conversations with the surety.

o. Verification of Payment

i. **Full Payment of the Claim is Made**

If full payment (including interest, as applicable) is made within the aforementioned 30-day period, the DME MAC shall, no later than 10 calendar days after payment was made:

A. Update all applicable records to reflect that payment was made. (Payment from the surety shall be treated as payment from the supplier for purposes of said record updates.)

B. Send a mailed, faxed, or (preferably) e-mailed letter to the supplier (on which the NSC shall be copied):

- Stating that payment has been made, the date the payment was received, and the amount of the payment

- Containing the following quoted verbiage:

"You must, within 30 calendar days of the date of this letter, obtain and submit to the NSC additional surety bond coverage in the amount of (insert the amount that the surety paid) so as to ensure that your total coverage equals or exceeds the required $50,000 amount" (or higher if an elevated bond amount is involved due to a final adverse action). "**Failure to timely do so will result in the revocation of your Medicare enrollment.**

"Additional surety bond coverage may be obtained by (1) adding to the amount of your existing surety bond so as to equal or exceed $50,000, or (2) cancelling your current surety bond and securing a new $50,000 surety bond. (Obtaining a separate (insert the amount the surety paid) surety bond is impermissible.) In either case, the effective date of the additional coverage must be on or before the date that you submit the additional coverage to the NSC.

If the NSC does not receive the additional bond coverage within this 30-day period, it shall revoke the DMEPOS supplier's Medicare enrollment under § 424.535(a)(1) in accordance with existing procedures. (The effective date of revocation shall be the date on which the DME MAC received payment from the surety.) It is important that the NSC (1) monitor the supplier's surety bond status upon receiving a copy of the DME MAC's letter to the supplier and (2) take prompt action against the supplier (consistent with existing procedures) if the supplier does not secure and timely submit the required additional coverage.

ii. **No Payment of the Claim Made**

If the surety fails to make any payment within 30 calendar days of the date of the letter to the surety, the DME MAC shall:

A. Refer the debt to the Department of Treasury (by HIGLAS on the 120-day deadline) immediately upon the expiration of said 30-day timeframe (i.e., preferably on

the same day or the day after, but in all cases no later than the 120-day deadline for sending delinquent debts to the Department of Treasury) and as outlined in Pub. 100-06, chapter 4;

B. No later than 14 days after the 30-day period expires, contact the surety via e-mail or telephone to ascertain the reason for non-payment. Only one contact is necessary. A voice mail message may be left. The contractor shall document any attempts to contact the surety by telephone and the content of any resultant conversations with the surety.

C. No later than 14 days after Step B (above) has been completed – and if full payment still has not been received -- send the letter identified in Section 10.7.15 of this chapter to the surety.

D. Include information relating to the surety's non-payment in the report identified in section 10.2.5(A)(3)(o)(ii).

iii. Partial Payment of the Claim is Made

If the surety pays part of the claim within the 30-day period and a balance is still due and owing, the DME MAC shall do the following:

A. Refer the unpaid debt to the Department of Treasury (by HIGLAS on the 12-day deadline) immediately upon the expiration of said 30-day timeframe (i.e., preferably on the same day or the day after, but in all cases no later than the 120-day deadline for sending delinquent debts to the Department of Treasury) and as outlined in Pub. 100-06, chapter 4;

B. No later than 14 days after the 30-day period expires, contact the surety via e-mail or telephone to ascertain the reason for the partial non-payment. Only one contact is necessary. A voice mail message may be left. The contractor shall document any attempts to contact the surety by telephone and the content of any resultant conversations with the surety.

C. No later than 14 days after Step (ii) has been completed – and if full payment still has not been received -- send the letter identified in Section 10.7.15 of this chapter to the surety.

D. Include information relating to the surety's partial non-payment in the report identified in section 10.2.5(A)(3)(o)(iii).

E. No later than 10 calendar days after the partial payment was made:

- Update all applicable records to reflect that partial payment was made. (Payment from the surety shall be treated as payment from the supplier for purposes of said record updates.)

- Send a mailed, faxed, or (preferably) e-mailed letter to the supplier (on which the NSC shall be copied):

- Stating that partial payment was made, the date the payment was received, and the

amount of said payment

- Containing the following quoted verbiage:

"You must, within 30 calendar days of the date of this letter, obtain and submit to the NSC additional surety bond coverage in the amount of (insert the amount that the surety paid) so as to ensure that your total coverage equals or exceeds the required $50,000 amount" (or higher if an elevated bond amount is involved due to a final adverse action). "**Failure to timely do so will result in the revocation of your Medicare enrollment**.

"Additional surety bond coverage may be obtained by (1) adding to the amount of your existing surety bond so as to equal or exceed $50,000, or (2) cancelling your current surety bond and securing a new $50,000 surety bond. (Obtaining a separate (insert the amount the surety paid) surety bond is impermissible.) In either case, the effective date of the additional coverage must be on or before the date that you submit the additional coverage to the NSC."

If the NSC does not receive the additional bond coverage within this 30- day period, it shall revoke the DMEPOS supplier*'s Medicare enrollment under §*424.535(a)(1) in accordance with existing procedures. (The effective date of revocation shall be the date on which the DME MAC received payment from the surety.) It is important that the NSC (1) monitor the supplier's surety bond status upon receiving a copy of the DME MAC's letter to the supplier and (2) take prompt action against the supplier (consistent with existing procedures) if the supplier does not secure and timely submit the required additional coverage.

iv. Successful Appeal

If the supplier successfully appeals the overpayment and the surety has already made payment to the DME MAC on the overpayment, the DME MAC shall – within 30 calendar days of receiving notice of the successful appeal - notify the surety via letter of the successful appeal and repay the surety via check or money order.

v. Summary

The following chart outlines the timeframes involved in the surety bond collection process for overpayments:

Day 1	Initial Demand Letter Sent
Day 31	Debt is Delinquent/Interest Starts
Day 41	Recoupment Starts
Day 66	Intent to Refer Letter Sent
Day 115	Surety Bond Letter Sent
Day 150	Referral to Treasury

4. Surety Bonds: Claims Pertaining to Assessments and Civil Monetary Penalties (CMPs)

a. Request for Payment from Surety

Per 42 CFR §424.57(a), an assessment is defined as a "sum certain that CMS or the OIG may assess against a DMEPOS supplier under Titles XI, XVIII, or XXI of the Social Security Act." Under 42 CFR §424.57(a), a CMP is defined as a sum that CMS has the authority, as implemented by 42 CFR §402.1(c) (or the OIG has the authority, under section 1128A of the Act or 42 CFR Part 1003) to impose on a supplier as a penalty.

The CMS will notify the DME MAC of the need for the latter to collect payment from the surety on an assessment or CMP imposed against a particular bonded DMEPOS supplier. Upon receipt of this notification, the DME MAC shall – regardless of the amount of the assessment or CMP - notify the surety via letter that, in accordance with 42 CFR § 424.57(d)(5)(i)(B), payment of the assessment or CMP must be made within 30 calendar days from the date of the letter. The letter (on which the NSC and the supplier/debtor shall be copied) shall:

- Follow the format of the applicable model letter in Pub. 100-08, Chapter 15, Sections 15.21.7.1.1.A through 15.21.7.1.1.E.

- Identify the specific amount to be paid and be accompanied by "sufficient evidence." This includes all documentation that CMS (in its notification to the DME MAC as described above) requests the DME MAC to include with the letter (e.g., OIG letter).

- State that payment shall be made via check or money order and that the Payee shall be CMS.

- Identify the address to which payment shall be sent.

i. **Follow-Up Contact**

Between 8 and 12 calendar days after sending the surety letter, the DME MAC shall contact the surety by telephone or e-mail to determine whether the surety received the letter and, if it did, whether and when payment is forthcoming;

If the surety indicates that it did not receive the letter, the DME MAC shall immediately fax or e-mail a copy of the letter to the surety. The surety will have 30 days from the original date of the letter – not 30 days from the date the letter was resent to the surety – to submit payment. To illustrate, suppose the DME MAC on April 1 sends the surety letter, which is also dated April 1. It places the follow-up call to the surety on April 11. The surety states that it never received the letter, so the contractor e-mails a copy of it to the surety that same day. Payment must be received by May 1, or 30 days from the original date of the letter.

If the surety cannot be reached (including situations where a voicemail message must be left) or if the surety indicates that it received the letter and that payment is forthcoming, no further action by the contractor is required. If the surety indicates that payment is not forthcoming, the contractor shall (1) attempt to ascertain the reason, and (2) follow the steps outlined in section (A)(3)(b) below after the 30-day period expires.

The contractor shall document any attempts to contact the surety by telephone and the content of any resultant conversations with the surety.

ii. **Verification of Payment**

A. Full Payment of the Claim is Made

If full payment (including interest, as applicable) is made within 30 calendar days of the date of the letter to the surety, the DME MAC shall, no later than 10 calendar days after payment was made:

1. Update all applicable records to reflect that payment was made. (Payment from the surety shall be treated as payment from the supplier for purposes of said record updates.)

2. Notify the applicable CMS Regional Office (RO) via letter or e-mail that payment was made.

3. If the OIG imposed the CMP or assessment, notify the OIG via letter that payment was made.

4. Send a mailed, faxed, or (preferably) e-mailed letter to the supplier (on which the NSC shall be copied):

- Stating that payment has been made, the date the payment was received, and the amount of said payment

- Containing the following quoted verbiage:

"You must, within 30 calendar days of the date of this letter, obtain and submit to the NSC additional surety bond coverage in the amount of (insert the amount that the surety paid) so as to ensure that your total coverage equals or exceeds the required $50,000 amount" (or higher if an elevated bond amount is involved due to a final adverse action). "**Failure to timely do so will result in the revocation of your Medicare enrollment**.

"Additional surety bond coverage may be obtained by (1) adding to the amount of your existing surety bond so as to equal or exceed $50,000, or (2) cancelling your current surety bond and securing a new $50,000 surety bond. (Obtaining a separate (insert the amount the surety paid) surety bond is impermissible.) In either case, the effective date of the additional coverage must be on or before the date that you submit the additional coverage to the NSC."

If the NSC does not receive the additional bond coverage within this 30-day period, it shall revoke the DMEPOS supplier's Medicare enrollment under §424.535(a)(1) enrollment in accordance with existing procedures. (The effective date of revocation shall be the date on which the DME MAC received payment from the surety.) It is important that the NSC (1) monitor the supplier's surety bond status upon receiving a copy of the DME MAC's letter to the supplier and (2) take prompt action against the supplier (consistent with existing procedures) if the supplier does not secure and timely submit the required additional coverage.

B. No Payment of the Claim is Made

If the surety fails to make any payment within the aforementioned 30-day timeframe, the DME MAC shall:

1. Continue collection efforts as outlined in Pub. 100-06, chapter 4;

2. No later than 14 days after the 30-day period expires, contact the surety via e mail or telephone to ascertain the reason for non-payment. Only one contact is necessary. A voice mail message may be left. The contractor shall document any attempts to contact the surety by telephone and the content of any resultant conversations with the surety.

3. No later than 14 days after Step 2 has been completed – and if full payment still has not been received -- send the letter identified in Pub. 100-08, Chapter 15, Section 15.21.7.1.1.E to the surety.

4. Include information relating to the surety's non-payment in the report outlined in section 10.2.5(A)(3)(o)(ii).

C. Partial Payment of the Claim is Made

If the surety pays part of the claim within the 30-day period and a balance is still due and owing, the DME MAC shall do the following:

1. Continue collection efforts as outlined in Pub. 100-06, chapter 4;

2. No later than 14 days after the 30-day period expires, contact the surety via e-mail or telephone to ascertain the reason for the partial non- payment. Only one contact is necessary. A voice mail message may be left. The contractor shall document any attempts to contact the surety by telephone and the content of any resultant conversations with the surety.

3. No later than 14 days after Step (ii) has been completed – and if full payment still has not been received -- send the letter identified in Section 10.7.15 of this chapter to the surety.

4.Include information relating to the surety's partial non-payment in the report identified in 10.2.5(A)(3)(o)(iii).

5. No later than 10 calendar days after the partial payment was made:

- Update all applicable records to reflect that partial payment was made. (Payment from the surety shall be treated as payment from the supplier for purposes of said record updates.)

- Send a mailed, faxed, or (preferably) e-mailed letter to the supplier (on which the NSC shall be copied):

- Stating that partial payment was made, the date the payment was received, and the amount of said payment

- Containing the following quoted verbiage:

"You must, within 30 calendar days of the date of this letter, obtain and submit to the NSC additional surety bond coverage in the amount of (insert the amount that the surety paid) so as to ensure that your total coverage equals or exceeds the required $50,000 amount" (or higher if an elevated bond amount is involved due to a final adverse action). "**Failure to timely do so will result in the revocation of your Medicare enrollment**.

"Additional surety bond coverage may be obtained by (1) adding to the amount of your existing surety bond so as to equal or exceed $50,000, or (2) cancelling your current surety bond and securing a new $50,000 surety bond. (Obtaining a separate (insert the amount the surety paid) surety bond is impermissible.) In either case, the effective date of the additional coverage must be on or before the date that you submit the additional coverage to the NSC."

If the NSC does not receive the additional bond coverage within this 30-day period, it shall revoke the DMEPOS supplier's Medicare enrollment under §424.535(a)(1) in accordance with existing procedures. (The effective date of revocation shall be the date on which the DME MAC received payment from the surety.) It is important that the NSC (1) monitor the supplier's surety bond status upon receiving a copy of the DME MAC's letter to the supplier and (2) take prompt action against the supplier (consistent with existing procedures) if the supplier does not secure and timely submit the required additional coverage.

D. Successful Appeal

If the DMEPOS supplier successfully appeals the CMP or assessment and the surety has already made payment, CMS will – within 30 days of receiving notice of the successful appeal - notify the surety via letter of the successful appeal and repay the surety.

B. Indian Health Services (IHS) Facilities' Enrollment as DMEPOS Suppliers

1. Background

The National Supplier Clearinghouse (NSC) shall enroll IHS facilities as DMEPOS suppliers in accordance with (a) the general enrollment procedures cited in chapter 10, (b) the statement of work contained in the NSC contract with Medicare, and (c) the special procedures cited in this section.

For enrollment purposes, Medicare recognizes two types of IHS facilities: (1) facilities wholly owned and operated by the IHS, and (2) facilities owned by the HIS but tribally operated or totally owned and operated by a tribe. CMS will provide the NSC with a list of IHS facilities that distinguishes between these two types.

On the list, the NSC shall use the column entitled, "FAC OPERATED BY", for this purpose.

2. Enrollment

The provider/supplier shall complete the Form CMS-855S in accordance with the instructions shown therein.

Facilities that are:

- Totally owned and operated by the IHS are considered governmental organizations. An Area Director of the IHS must sign section 15 of the Form CMS–855S, be listed in section 9 of the form, and sign the letter required under section 8 of the form that attests that the IHS will be legally and financially responsible in the event there is any outstanding debt owed to CMS.

- Tribally operated are considered tribal organizations. Section 15 of the Form CMS–855S must be signed by a tribal official who meets the definition of an "authorized official" under 42 CFR § 424.502. The individual must also be listed in section 9 of the form, and must sign the letter required under section 8 of the form that attests that the tribe will be legally and financially responsible in the event there is any outstanding debt owed to CMS.

3. Supplier Standards, Exceptions and Site Visits

All IHS facilities, whether operated by the IHS or a tribe:

- Shall meet all required standards, with the exception of:

- The comprehensive liability insurance requirements under 42 CFR 424.57(c)(10).

- The requirement to provide State licenses for their facility/business. For example, if the DMEPOS supplier indicates on its application that it will be providing hospital beds and is located in a State that requires a bedding license, such licensure is not required. However, if it provides a DMEPOS item that requires a licensed professional in order to properly provide the item, it shall provide a copy of the professional license. The licensed professional can be licensed in any State or have a Federal license (e.g., a pharmacy does not need a pharmacy license, but shall have a licensed pharmacist).

- Shall, like all other DMEPOS suppliers, undergo site visits in accordance with Pub. 100-08, Chapter 15, Section 15.19.2.2. (This includes all hospitals and pharmacies enrolling as DMEPOS suppliers.)

4. Provider Education for IHS Facilities

The NSC shall ensure that its Web site includes the information contained in this section 10.2.5(B) that is specific to enrollment of IHS facilities (whether operated by the IHS or a tribe).

5. Specialty Codes

The NSC shall apply the specialty code A9 (IHS) to all IHS enrollments (whether operated by the IHS or a tribe). However, the specialty code A9/A0 shall be applied to facilities that are IHS/tribal hospitals.

Other specialty codes should be applied as applicable (e.g., pharmacies).

C. Pharmacies' Enrollment as DMEPOS Suppliers

Refer to 10.2.2(D) for a discussion of pharmacy enrollment via the Form CMS-855B (i.e., pharmacy not enrolling as a DMEPOS supplier).

1. Compliance Standards for Pharmacy Accreditation

The National Supplier Clearinghouse (NSC) shall not require that a pharmacy be accredited as a condition of enrollment before January 1, 2011.

The NSC-Medicare Administrative Contractor (MAC) shall determine which enrolled suppliers are pharmacies that are not accredited and who will be enrolled for 5 calendar years prior to January 1 of the next calendar year. The NSC-MAC shall then send a notice of revocation by January 10, 2011, to all enrolled pharmacies that are not accredited and who will not be enrolled for 5 calendar years as of January 1, 2011.

The NSC-MAC shall prepare a letter which enables all individually enrolled practice locations of pharmacies who have been enrolled for 5 calendar years prior to January 1, 2011, to attest that they are exempt from the requirement to be accredited because their total durable medical equipment, prosthetics orthotics and supplies (DMEPOS) billings subject to accreditation are less than 5 percent of their total pharmacy sales, as determined based upon the total pharmacy sales of the pharmacy for the previous 3 calendar or fiscal years. The letter shall cite that the attestation requires the signature of the authorized or delegated official of the entity. The authorized and delegated officials are defined in Section 15, of the Medicare Enrollment Application (CMS-855S), and as described in the internet enrollment application version of the Provider Enrollment, Chain and Ownership System (PECOS). Before mailing the letters, the NSC-MAC shall obtain NSC project officer approval of the letter. The mailing shall be in the form of an endorsement letter with an enclosed stamped self-addressed envelope. The mailing should be performed between October 1, 2010 and October 31, 2010. For pharmacies with more than one practice location, the letters shall cite the need for each individually enrolled practice location to attest that they are exempt from the accreditation requirements. New locations of enrolled chain pharmacies shall not be considered to have been enrolled for 5 calendar years. Pharmacies that have had a change of ownership in the prior 5 years which resulted in a change in their legal business entity, including a change in their tax identification number (TIN), shall not qualify for an attestation accreditation exemption and therefore shall not be sent the attestation letter.

The NSC-MAC shall review the attestations received from pharmacies. Pharmacies that properly signed the attestation letter shall be given an accreditation status of exempt. The NSC shall make attempts to assist and follow-up with pharmacy suppliers that have not submitted or properly completed their attestations. The NSC-MAC shall send a notice of revocation by January 10, 2011, to all enrolled pharmacies who were sent an attestation letter and have not properly completed it as of the date of the notice of revocation. The notice of revocation shall cite that the revocation is for a lack of required accreditation.

Between April 1, 2011 and April 30, 2011, the NSC-MAC shall compile a sample listing of at least 10 percent of the pharmacies that have submitted an NSC accepted attestation exempting them from accreditation. The NSC-MAC shall develop a letter to be sent to pharmacies that will be audited to determine if their accreditation exemption attestations are correct. The letter shall request submission of evidence substantiating that the validity of the pharmacy supplier's attestation. At a minimum, requested materials for this evidence shall include a certification by an accountant on behalf of the pharmacy or the submission of tax returns filed by the pharmacy during the relevant periods. The NSC-MAC shall obtain NSC project officer approval of the letter. Within 45 days after project officer approval of the letter the NSC-MAC shall mail a copy of the letter to the random sample of pharmacies which claimed exemption through an attestation. The NSC-MAC shall determine the acceptability of the replies received in response

to the audit verification random sample mailing. The NSC shall use DMEPOS billing data for only products and services requiring accreditation to assist in the determination.

The NSC shall make attempts to assist and follow-up with pharmacy suppliers that have not submitted or properly completed their audit verifications. The NSC-MAC shall consult with the NSC project officer in cases where they are uncertain as to the acceptability of the supplier's response to the audit request. By June 30, 2011, the NSC-MAC shall send a notice of revocation to all enrolled pharmacies that were sent an audit verification letter who did not submit satisfactory evidence that they were in compliance with the requirements to obtain an accreditation exemption. The notice of revocation shall cite that the revocation is for a lack of required accreditation.

The NSC-MAC shall follow the procedures shown above concerning issuance of attestation letters and audit surve letters for all succeeding years after they have been performed for the first time.

Medicare Program Integrity Manual

Chapter 11 – Fiscal Administration

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(Rev. 10228; Issued: 07-27-20)

11.1.2 - Reporting MR Workload and Cost Information and Documentation in CAFM II

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

Workload information and associated workload cost information shall be maintained and documented on-site by all MR contractors. Each site shall maintain records of its own workload information and associated workload cost information. Contractors shall be able to provide this information upon request from RO and/or CO. Site-specific workload and cost information shall be reported in the remarks section of CAFM II. With RO consent, this information may be submitted by other means with an indication made in the remarks section of the CAFM II IER report.

The MR strategy shall include a section that describes the process used to monitor spending in each activity code. The process shall ensure that spending is consistent with the allocated budget and includes a process to revise the plan when spending is over or under the budget allocation. In addition, the strategy shall describe how workload for each activity code is accurately and consistently reported. The workload reporting process shall also assure proper allocation of employee hours required for each activity.

Contractor's MR workload records shall include workload information captured by the Interim Expenditure Report (IER). Only costs (direct, indirect, overhead) incurred to support MR activities are reported on the MR line. Contractors are responsible for ensuring the accuracy of the information contained in CAFM II. The contractor shall alert the RO (for *UPICs*, the GTL, Associate GTL, and SME) to any software or hardware problems that hinder the contractor's ability to report accurate data in CAFM II. The contractor should cc MROperations@CMS.HHS.gov.

11.1.3.6 - MR Program Management Costs (Activity Code 21207)

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

The MR Program Management encompasses managerial responsibilities inherent in managing the MR program, including: development, modification, and periodic reporting of MR strategy and quality assurance activities; planning monitoring and adjusting workload performance; budget-related monitoring and reporting; and implementation of CMS instructions.

Activity Code 21207 is designed to capture the costs of managerial oversight for the following tasks:

- Develop and periodically modify MR strategy;
- Develop and modify quality assurance activities, including special studies, inter- reviewer reliability testing, committee meetings, and periodic reports;
- Evaluate edit effectiveness;
- Plan, monitor and oversee budget, including interactions with contractor budget staff and RO budget and MR program staff;
- Manage workload, including monitoring of monthly workload reports, reallocation of staff resources, and shifts in workload focus when indicated;

- Implement MR instructions from regional and/or central office;

- Educate staff on MR program, new CMS instructions, and quality assurance findings (this is different from the internal training of MR staff to perform MR activities); and,

- Support service for *UPIC* performing MR activities other than for the CERT contractor.

11.2.1 - Reporting LPET Workload and Cost Information and Documentation in CAFM II

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

Workload information and associated workload cost information shall be maintained and documented on site by all contractors. Each site shall maintain records of its own workload information and associated workload cost information. Contractors shall be able to provide this information upon request from RO and/or CO. Site-specific workload and cost information should be reported in the remarks section of CAFM II. With RO consent, this information may be submitted by other means with an indication made in the remarks section of the CAFM II IER report.

The contractors' LPET workload records shall include workload information captured by the Interim Expenditure Report (IER). Only costs (direct, indirect, overhead) incurred in LPET activities are reported in CAFM II activity codes. Analysis of the data to develop and deliver LPET interventions shall be reported in an associated LPET activity code.

Contractors are responsible for ensuring the accuracy of the information contained in CAFM II. The contractor shall alert the RO (for *UPICs*, the GTL, Co-GTL, and SME) to any software or hardware problems that hinder the contractor's ability to report accurate data on CAFM II.

Since LPET is related to medical review activities, Joint Operating Agreements between *Unified Program Integrity Contractors (UPIC)* and Affiliated Contractors (AC) should reflect proportionate allocation of tasks delineated to MR and LPET. When negotiating Joint Operating Agreements, the *UPICs* should be cognizant of their task order.

Medicare Program Integrity Manual

Exhibits

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(Rev. 10228; Issued: 07-27-20)

Transmittals for Exhibits

Exhibit 1 - Definitions

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

A

Abuse

Billing Medicare for services that are not covered or are not correctly coded.

Affiliated Contractor (AC)

A Medicare carrier, Fiscal Intermediary (FI), or other contractor such as a Durable Medical Equipment Medicare Administrative Contractor (DME MAC), which shares some or all of the *Unified Program Integrity Contractor's (UPIC's)* jurisdiction; Affiliated Contractors perform non-*UPIC* Medicare functions such as claims processing.

B-C

Carrier

The Carrier is an entity that has entered into a contract with CMS to process Medicare claims under Part B for non-facility providers (e.g., physicians, suppliers, laboratories). DME MACs are those carriers that CMS has designated to process DME, prosthetic, orthotic and supply claims.

Case

A case exists when the *UPIC* or Medicare contractor BI unit has referred a fraud allegation to law enforcement, including but not limited to, documented allegations that: a provider, beneficiary, supplier, or other subject has a) engaged in a pattern of improper billing, b) submitted improper claims with actual knowledge of their truth or falsity, or c) submitted improper claims with reckless disregard or deliberate ignorance of their truth or falsity.

Contractor

Contractor includes all intermediaries, carriers, DME MAC, RHHIs, MACs, and *UPICs*.

Centers for Medicare & Medicaid Services (CMS)

CMS administers the Medicare program. CMS' responsibilities include management of AC and Medicare contractor claims payment, managing *UPIC*, AC, and Medicare contractor fiscal audit and/or overpayment prevention and recovery, and the development and the monitoring of payment safeguards necessary to detect and respond to payment errors or abusive patterns of service delivery. CMS was formerly known as the Health Care Financing Administration (HCFA).

Closed Case

A FID case shall be closed when no further action will be required of the *UPIC*, or Medicare contractor BI unit by the law enforcement agency(ies) working the case and when the law enforcement agency(ies) has ended all its activity on the case. Note that even after the case is closed, there may still be administrative actions that the *UPIC*, or Medicare contractor BI unit will take.

D-E

Department of Justice (DOJ)

Attorneys from DOJ and United States Attorney's Offices have criminal and civil authority to prosecute those providers who de-fraud the Medicare program.

Demand Bill or Demand Claim

A demand bill or demand claim is a complete, processable claim that must be submitted promptly to Medicare by the physician, supplier or provider at the timely request of the beneficiary, the beneficiary's representative, or, in the case of a beneficiary dually entitled to Medicare and Medicaid, a state as the beneficiary's subrogee. A demand bill or demand claim is requested usually, but not necessarily, pursuant to notification of the beneficiary (or representative or subrogee) of the fact that the physician, supplier or provider expects Medicare to deny payment of the claim. When the beneficiary (or representative or subrogee) selects an option on an advance beneficiary notice that includes a request that a claim be submitted to Medicare, no further demand is necessary; a demand bill or claim must be submitted.

F

Federal Bureau of Investigation (FBI)

Along with OIG, the FBI investigates potential health care fraud. Under a special memorandum of understanding, the FBI has direct access to contractor data and other records to the same extent as OIG.

Fraud

Fraud is the intentional deception or misrepresentation that the individual knows to be false or does not believe to be true, and the individual makes knowing that the deception could result in some unauthorized benefit to himself/herself or some other person.

G-H

I

Intermediary

The intermediary is a public or private agency or organization that has entered into an agreement with CMS to process Medicare claims under both Part A and Part B for institutional providers (e.g., hospitals, SNFs, HHAs, hospices, CORFs, OPT, occupational therapy, speech pathology providers, and ESRD facilities). Regional home health intermediaries (RHHIs) are those FIs that CMS has designated to process Medicare claims received from home health and hospice providers.

J-K-L

Local Coverage Determinations (LCDs)

The LCDs are those policies used to make coverage and coding decisions in the absence of specific statute, regulations, national coverage policy, national coding policy, or as an adjunct to a national coverage policy.

M

Medicare Contractor (Benefit Integrity)

Medicare contractors include all intermediaries and carriers that have not transitioned their benefit integrity work to a *UPIC*.

Medicare Contractor (Medical Review)

Medicare contractors include intermediaries, carriers and MACs.

Misrepresented

A deliberate false statement made, or caused to be made, that is material to entitlement or payment under the Medicare program.

N

Noncovered (Not Covered)

Noncovered services are those for which there is no benefit category, services that are statutorily excluded (other than §1862 (A)(1)(a)), or services that are not reasonable and necessary under §1862 (A)(1)(a).

O

Office of Audit Services (OAS)

The OAS conducts comprehensive audits to promote economy and efficiency and to prevent and detect fraud, abuse, and waste in operations and programs. OAS may request data for use in auditing aspects of Medicare and other Health and Human Service (HHS) programs and is often involved in assisting OIG/OI in its role in investigations and prosecutions.

Office of Counsel to the Inspector General (OCIG)

The OCIG is responsible for coordinating activities that result in the negotiation and imposition of Civil Monetary Penalties (CMPs), assessments, and other program exclusions. It works with the Office of Investigations (OIG), Office of Audit Services (OAS), CMS, and other organizations in the development of health care fraud and exclusions cases.

Office of Inspector General (OIG)

The OIG investigates suspected fraud or abuse and performs audits and inspections of CMS programs. In carrying out its responsibilities, OIG may request information or assistance from CMS, its *Unified Program Integrity Contractor (UPIC)*, Medicare contractors, and QIOs. OIG has access to CMS's files, records, and data as well as those of CMS'scontractors. OIG investigates fraud, develops cases, and has the authority to take action against individual health

care providers in the form of CMPs and program exclusion, and to refer cases to the DOJ for criminal or civil action. OIG concentrates its efforts in the following areas:

- Conducting investigations of specific providers suspected of fraud, waste, or abuse for purposes of determining whether criminal, civil, or administrative remedies are warranted;
- Conducting audits, special analyses and reviews for purposes of discovering and documenting Medicare and Medicaid policy and procedural weaknesses contributing to fraud, waste, or abuse, and making recommendations for corrections;
- Conducting reviews and special projects to determine the level of effort and performance in health provider fraud and abuse control;
- Participating in a program of external communications to inform the health care community, the Congress, other interested organizations, and the public of OIG's concerns and activities related to health care financing integrity;
- Collecting and analyzing Medicare contractor, AC, Medicare contractor, and State Medicaid agency-produced information on resources and results; and,
- Participating with other government agencies and private health insurers in special programs to share techniques and knowledge on preventing health care provider fraud and abuse.

Office of Investigations (OI)

The Office of Investigations (OI), within OIG, is staffed with professional criminal investigators and is responsible for all HHS criminal investigations, including Medicare fraud. OIG/OI investigates allegations of fraud or abuse whether committed by *UPICs*, ACs, Medicare contractors, grantees, beneficiaries, or providers of service (e.g., fraud allegations involving physicians and other providers, contract fraud, and cost report fraud claimed by hospitals).

The OIG/OI presents cases to the United States Attorney's Office within the Department of Justice (DOJ) for civil or criminal prosecution. When a practitioner or other person is determined to have failed to comply with its obligations in a substantial number of cases or to have grossly and flagrantly violated any obligation in one or more instances, OIG/OI may refer the case to OCIG for consideration of one or both of the following sanctions:

- An exclusion from participation in the Medicare program or any State health care programs as defined under §1128(h) of the Social Security Act (the Act); or
- The imposition of a monetary penalty as a condition to continued participation in the Medicare program and State health care programs.

Offset

The recovery by Medicare of a non-Medicare debt by reducing present or future Medicare payments and applying the amount withheld to the indebtedness.

P

Providers

Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, renal dialysis facility, hospice, physician, non-physician practitioner, laboratory, supplier, etc.). For purposes of this manual, the term provider is generally used to refer to individuals or organizations that bill carriers, intermediaries, DME MACs, and RHHIs. If references apply to only specific providers (e.g., physicians), the specific provider will be identified.

Q- R

Quality Improvement Organization (QIO)

The Peer Review Improvement Act of 1982 established the utilization and quality control peer review organization (PRO) program. The PRO name has changed to quality improvement organization. CMS contracts with independent physician organizations in each state to administer the QIO program. Their purpose is to ensure that the provisions of the Peer Review Improvement Act of 1982 are met. Under their contracts with CMS, QIOs are required to perform quality of care reviews of the medical services provided to Medicare beneficiaries in settings including, but not limited to: physician offices, acute care hospitals, specialty hospitals (for example psychiatric and rehabilitation hospitals), and ambulatory surgical centers. In the inpatient setting, QIOs also perform provider-requested higher-weighted DRG reviews for acute inpatient prospective payment system (IPPS) hospitals and long-term care hospital (LTCH) claims.

Recoupment

The recovery by Medicare of any outstanding Medicare debt by reducing present or future Medicare payments and applying the amount withheld to the indebtedness.

Reliable Information

Reliable information includes credible allegations, oral or written, and/or other material facts that would likely cause a non-interested third party to think that there is a reasonable basis for believing that a certain set of facts exists, for example, that claims are or were false or were submitted for non-covered or miscoded services. Reliable information of fraud exists if the following elements are found:

- The allegation is made by a credible person or source. The source is knowledgeable and in a position to know. The source experienced or learned of the alleged act first hand, i.e., saw it, heard it, read it. The source is more credible if the source has nothing to gain by not being truthful. The source is competent; e.g., a beneficiary may not always be a credible source in stating that services received were not medically necessary. An employee of a provider who holds a key management position and who continues to work for the provider is often a highly credible source. The friend of a beneficiary who heard that the provider is defrauding Medicare may not be a particularly credible source;
- The information is material. The information supports the allegation that fraud has been committed by making it more plausible, reasonable, and probable (e.g., instructions handwritten by the provider delineating how to falsify claim forms).

- The act alleged is not likely the result of an accident or honest mistake. For example, the provider was already educated on the proper way to complete the form, or the provider should know that billing for a service not performed is inappropriate, or claims are submitted the same way over a period of time by different employees.

Reliable evidence includes but is not limited to the following:

- Documented allegations from credible sources that items or services were not furnished or received as billed;
- Billing patterns so aberrant from the norm that they bring into question the correctness of the payments made or about to be made;
- Data analysis that shows the provider's utilization to be well above that of its peers without any apparent legitimate rationale for this;
- Statements by beneficiaries and/or their families attesting to the provider's fraudulent behavior;
- Corroboration from provider employees (official and unofficial whistle blowers);
- Other sources, such as prepayment and postpayment review of medical records; or
- Recommendations for suspension by OIG/OI, FBI, Assistant U.S. Attorneys (AUSAs), or CMS, based on their finding that the provider has already received overpayments and continued payments should be made only after a determination that continued payment is appropriate.

S

Services

Medical care, items, such as medical diagnosis and treatment, drugs and biologicals, supplies, appliances, and equipment, medical social services, and use of hospital RPCH or SNF facilities. (42CFR 400.202). In other sections of Medicare manuals and remittance advice records, the term item/service is used. However, throughout this manual we will use the term service to be inclusive of item/service. See §1861 of Title 18 for a complete description of services by each provider type.

Suspension of Payment

Suspension of payment is defined in the regulation 42CFR 405.370 as "the withholding of payment by the carrier or intermediary from a provider or supplier of an approved Medicare payment amount before a determination of the amount of overpayment exists." In other words, ACs or Medicare contractors have received processed and approved claims for a provider's items or services; however, the provider has not been paid and the amount of the overpayment has not been established.

T-U-V-W-X

Unified Program Integrity Contractor (UPIC)

The UPIC is a contractor dedicated to program integrity that handles such functions as audit, medical review and potential fraud and abuse investigations consolidated into a single contract.

Exhibit 16 - Model Payment Suspension Letters

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

A. Payment Suspension Initial Notice Based on Fraud (No Prior Notice Given)

Date
Name of Addressee (if known) Name of Medicare Provider/Supplier
Address
City, State Zip

Re: Notice of Suspension of Medicare Payments
Provider/Supplier Medicare ID Number(s):
Provider/Supplier NPI:
PSP Number:

Dear {Medicare Provider/Supplier's Name}:

The purpose of this letter is to notify you of our determination to suspend your Medicare payments {INSERT THE FOLLOWING IF THIS IS A NATIONAL PAYMENT SUSPENSION: in all jurisdictions} pursuant to 42 C.F.R. § 405.371(a)(2). The suspension of your Medicare payments took effect on {ENTER DATE}. Prior notice of this suspension was not provided, because giving prior notice would place additional Medicare funds at risk and hinder our ability to recover any determined overpayment. See 42 C.F.R. § 405.372(a)(3).

The decision to suspend your Medicare payments was made by the Centers for Medicare & Medicaid Services (CMS) through its Central Office. See 42 C.F.R. § 405.372(a)(4)(iii). This suspension is based on credible allegations of fraud. CMS regulations define credible allegations of fraud as an allegation from any source including, but not limited to, Fraud hotline complaints, claims data mining, patterns identified through audits, civil false claims cases, and law enforcement investigations. Allegations are considered to be credible when they have indicia of reliability. See 42 C.F.R. § 405.370. This suspension may last until "resolution of the investigation" as defined under 42 C.F.R. § 405.370 and may be extended under certain circumstances. See 42 C.F.R. § 405.372(d)(3)(i)-(ii). Specifically, the suspension of your Medicare payments is based on, but not limited to, information that you misrepresented services billed to the Medicare program. More particularly, {Continue with further supportive information and specific examples (no less than five). Only use claim numbers, Date of Service and amount paid when referencing the specific claim examples. Do Not use beneficiary names or HIC#s in the notice.}

The following list of sample claims provide evidence of our findings and serve as a basis for the determination to suspend your Medicare payments:

Claim Control Number	Date(s) of Service	$$ Amount Paid

This list is not exhaustive or complete in any sense, as the investigation into this matter is continuing. The information is provided by way of example in order to furnish you with adequate notice of the basis for the payment suspension noticed herein.

Pursuant to 42 C.F.R. § 405.372(b)(2), you have the right to submit a rebuttal statement in writing to us indicating why you believe the suspension should be removed. We request that you submit this rebuttal statement to us within 15 days. You should include with this statement any evidence you believe is pertinent to your reasons why the suspension should be removed. Your rebuttal statement and any pertinent evidence should be sent to:

Your Name, Program Integrity Analyst
{ADDRESS}

If you submit a rebuttal statement, we will review that statement (and any supporting documentation) along with other materials associated with the case. Based on a careful review of the information you submit and all other relevant information known to us, we will determine whether the suspension should be removed, modified, or should remain in effect within 15 days of receipt of the complete rebuttal package. However, the suspension of your Medicare funds will continue while your rebuttal package is being reviewed. Thereafter, we will notify you in writing of our determination to continue or remove the suspension and provide specific findings on the conditions upon which the suspension may be continued or removed, as well as an explanatory statement of the determination. See 42 C.F.R. § 405.375(b)(2). This determination is not administratively appealable. See 42 C.F.R. § 405.375(c).

If the suspension is continued, we will review additional evidence during the suspension period to determine whether claims are payable and/or whether an overpayment exists and, if so, the amount of the overpayment. See 42 C.F.R. § 405.372(c). We may need to contact you with specific requests for further information. You will be informed of developments and will be promptly notified of any overpayment determination. Claims will continue to be processed during the suspension period, and you will be notified about bill/claim determinations, including appeal rights regarding any bills/claims that are denied. The payment suspension applies to both current and future payments.

In the event that an overpayment is determined and it is determined that a recoupment of payments under 42 C.F.R. § 405.371(a)(3) should be put into effect, you will receive a separate written notice of the intention to recoup and the reasons. You will be given an opportunity for rebuttal in accordance with 42 C.F.R. § 405.374 from {MAC name.}. When the payment suspension has been removed, any money withheld as a result of this action shall be first be applied to reduce or eliminate the determined overpayment and then to reduce any other obligation to CMS or to the U.S. Department of Health and Human Services in accordance with 42 C.F.R. § 405.372(e). In the absence of a legal requirement that the excess be paid to another entity, the excess will be released to you.

{Insert the following paragraph if prepayment review is being initiated:} Finally, {Name of *UPIC* or MAC}, a CMS {*Unified Program Integrity Contractor (UPIC)* or Medicare Administrative Contractor (MAC)}, has initiated a process to review your Medicare claims and supporting documentation prior to payment. The purpose of implementing this prepayment process is to ensure that all payments made by the Medicare program are appropriate and consistent with Medicare rules, regulations and policy. The prepayment process is often applied to safeguard Medicare from unnecessary expenditures and to ensure that Medicare payments are made for items and services which are “reasonable and necessary” for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. See Social Security Act

§1862(a)(1)(A). Notification is hereby given that you are expected to comply with the prepayment process for claims for all dates and services.

Should you have any questions, please contact me in writingor via telephone at {phone number}. Sincerely,

Name

B. Payment Suspension Initial Notice Based on Fraud (Prior Notice Given)

Date
Name of Addressee (if known)
Name of Medicare Provider/Supplier
Address
City, State Zip

Re: Notice of Suspension of Medicare Payments
Provider/Supplier Medicare ID Number(s):
Provider/Supplier NPI:
PSP Number:

Dear {Medicare Provider/Supplier's Name}:

The purpose of this letter is to notify you of our determination to suspend your Medicare payments {INSERT THE FOLLOWING IF THIS IS A NATIONAL PAYMENT SUSPENSION: in all jurisdictions} pursuant to 42 C.F.R. § 405.371(a)(2). The suspension of your Medicare payments will take effect on {ENTER DATE}.

The decision to suspend your Medicare payments was made by the Centers for Medicare & Medicaid Services (CMS) through its Central Office. See 42 C.F.R. § 405.372(a)(4)(iii). This suspension is based on credible allegations of fraud. CMS regulations define credible allegations of fraud as an allegation from any source including, but not limited to, Fraud hotline complaints, claims data mining, patterns identified through audits, civil false claims cases, and law enforcement investigations. Allegations are considered to be credible when they have indicia of reliability. See 42 C.F.R. § 405.370. This suspension may last until "resolution of the investigation" as defined under 42 C.F.R. § 405.370 and may be extended under certain circumstances. See 42 C.F.R. § 405.372(d)(3)(i)-(ii). Specifically, the suspension of your Medicare payments is based on, but not limited to, information that you misrepresented services billed to the Medicare program. More particularly, {Continue with further supportive information and specific examples (no less than five). Only use claim numbers, Date of Service and amount paid when referencing the specific claim examples. Do Not use beneficiary names or HIC#s in the notice.}

The following list of sample claims provide evidence of our findings and serve as a basis for the determination to suspend your Medicare payments:

Claim Control Number	Date(s) of Service	$$ Amount Paid

This list is not exhaustive or complete in any sense, as the investigation into this matter is continuing. The information is provided by way of example in order to furnish you with adequate notice of the basis for the payment suspension noticed herein.

Pursuant to 42 C.F.R. § 405.372(b)(2), you have the right to submit a rebuttal statement in writing to us within the next 15 days indicating why you believe the suspension should be removed. You should include with this statement any evidence you believe is pertinent to your reasons why the suspension should be removed. Your rebuttal statement and any pertinent evidence should be sent to:

Your Name, Program Integrity Analyst
{ADDRESS}

If you submit a rebuttal statement, we will review that statement (and any supporting documentation) along with other materials associated with the case. Based on a careful review of the information you submit and all other relevant information known to us, we will determine whether the suspension should be removed, modified, or should remain in effect within 15 days of receipt of the complete rebuttal package. Thereafter, we will notify you in writing of our determination to continue or remove the suspension and provide specific findings on the conditions upon which the suspension may be continued or removed, as well as an explanatory statement of the determination. See 42 C.F.R. § 405.375(b)(2). However, if by the end of this period no rebuttal has been received, the payment suspension will go into effect automatically. This determination is not administratively appealable. See 42 C.F.R. § 405.375(c).

If the suspension is continued, we will review additional evidence during the suspension period to determine whether claims are payable and/or whether an overpayment exists and, if so, the amount of the overpayment. See 42 C.F.R. § 405.372(c). We may need to contact you with specific requests for further information. You will be informed of developments and will be promptly notified of any overpayment determination. Claims will continue to be processed during the suspension period, and you will be notified about bill/claim determinations, including appeal rights regarding any bills/claims that are denied. The payment suspension applies to both current and future payments.

In the event that an overpayment is determined and it is determined that a recoupment of payments under 42 C.F.R. § 405.371(a)(3) should be put into effect, you will receive a separate written notice of the intention to recoup and the reasons. You will be given an opportunity for rebuttal in accordance with 42 C.F.R. § 405.374 from {MAC name.} When the payment suspension has been removed, any money withheld as a result of this action shall be first be applied to reduce or eliminate the determined overpayment and then to reduce any other obligation to CMS or to the U.S. Department of Health and Human Services in accordance with 42 C.F.R. § 405.372(e). In the absence of a legal requirement that the excess be paid to another entity, the excess will be released to you.

{Insert the following paragraph if prepayment review is being initiated:} Finally, {Name of *UPIC* or MAC}, a CMS {*Unified Program Integrity Contractor (UPIC)* or Medicare Administrative Contractor (MAC)}, has initiated a process to review your Medicare claims and supporting documentation prior to payment. The purpose of implementing this prepayment process is to ensure that all payments made by the Medicare program are appropriate and consistent with Medicare rules, regulations and policy. The prepayment process is often applied to safeguard Medicare from unnecessary expenditures and to ensure that Medicare payments are made for items and services which are “reasonable and necessary” for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. See Social Security Act § 1862(a)(1)(A). Notification is hereby given that you are expected to comply with the prepayment process for claims for all dates and services.

Should you have any questions, please contact me in writing or via telephone at {phone number}.

Sincerely,

Name

C. Payment Suspension Initial Notice Based on Reliable Information (No Prior Notice Given)

Date
Name of Addressee (if known)
Name of Medicare Provider/Supplier
Address
City, State Zip

Re: Notice of Suspension of Medicare Payments
Provider/Supplier Medicare ID Number(s):
Provider/Supplier NPI:
PSP Number:

Dear {Medicare Provider/Supplier's Name}:

The purpose of this letter is to notify you of our determination to suspend your Medicare payments {INSERT THE FOLLOWING IF THIS IS A NATIONAL PAYMENT SUSPENSION: in all jurisdictions} pursuant to 42 C.F.R. § 405.371(a)(1). The suspension of your Medicare payments took effect on {ENTER DATE}. This payment suspension may last for up to 180 days from the effective date and may be extended under certain circumstances. See 42 C.F.R. § 405.372(d). Any delays in producing medical records linked to the payment suspension request will likely extend this period beyond the 180 days. Prior notice of this suspension was not provided, because giving prior notice would place additional Medicare funds at risk and hinder our ability to recover any determined overpayment. See 42 C.F.R. § 405.372(a)(3).

The decision to suspend your Medicare payments was made by the Centers for Medicare & Medicaid Services (CMS) through its Central Office. The suspension of your Medicare payments is based on reliable information that an overpayment exists or that the payments to be made may not be correct. Specifically, the suspension of your Medicare payments is based on, but not limited to, information from claims data analysis and medical review completed by {NAME OF *UPIC* or MAC.} More particularly, {Continue with further supportive information and specific claim examples (no less than five). Only use claim numbers, Date of Service and amount paid when referencing the claim examples. Do Not use beneficiary names or HIC#s in the notice.}

The following list of sample claims provide evidence of our findings and serve as a basis for the determination to suspend your Medicare payments:

Claim Control Number	Date(s) of Service	$$ Amount Paid

This list is not exhaustive or complete in any sense, as the investigation into this matter is continuing. The information is provided by way of example in order to furnish you with adequate notice of the basis for the payment suspension noticed herein.

Pursuant to 42 C.F.R. § 405.372(b)(2), you have the right to submit a rebuttal statement in writing to us indicating why you believe the suspension should be removed. We request that you submit this rebuttal statement to us within 15 days. You should include with this statement any evidence you believe is pertinent to your reasons why the suspension should be removed. Your rebuttal statement and any pertinent evidence should be sent to:

Your Name, Program Integrity Analyst
{ADDRESS}

If you submit a rebuttal statement, we will review that statement (and any supporting documentation) along with other materials associated with the case. Based on a careful review of the information you submit and all other relevant information known to us, we will determine whether the suspension should be removed, modified, or should remain in effect within 15 days of receipt of the complete rebuttal package. However, the suspension of your Medicare funds will continue while your rebuttal package is being reviewed. Thereafter, we will notify you in writing of our determination to continue or remove the suspension and provide specific findings on the conditions upon which the suspension may be continued or removed, as well as an explanatory statement of the determination. See 42 C.F.R. § 405.375(b)(2). This determination is not administratively appealable. See 42 C.F.R. § 405.375(c).

If the suspension is continued, we will review additional evidence during the suspension period to determine whether claims are payable and/or whether an overpayment exists and, if so, the amount of the overpayment. See 42 C.F.R. § 405.372(c). We may need to contact you with specific requests for further information. You will be informed of developments and will be promptly notified of any overpayment determination. Claims will continue to be processed during the suspension period, and you will be notified about bill/claim determinations, including appeal rights regarding any bills/claims that are denied. The payment suspension applies to both current and future payments.

In the event that an overpayment is determined and it is determined that a recoupment of payments under 42 C.F.R. § 405.371(a)(3) should be put into effect, you will receive a separate written notice of the intention to recoup and the reasons. You will be given an opportunity for rebuttal in accordance with 42 C.F.R. § 405.374 from {MAC name.}. When the payment suspension has been removed, any money withheld as a result of this action shall be first be applied to reduce or eliminate the determined overpayment and then to reduce any other obligation to CMS or to the U.S. Department of Health and Human Services in accordance with 42 C.F.R. § 405.372(e). In the absence of a legal requirement that the excess be paid to another entity, the excess will be released to you.

{Insert the following paragraph if prepayment review is being initiated:} Finally, {Name of *UPIC* or MAC}, a CMS {*Unified Program Integrity Contractor (UPIC)* or Medicare Administrative Contractor (MAC)}, has initiated a process to review your Medicare claims and supporting documentation prior to payment. The purpose of implementing this prepayment process is to ensure that all payments made by the Medicare program are appropriate and consistent with Medicare rules, regulations and policy. The prepayment process is often applied to safeguard Medicare from unnecessary expenditures and to ensure that Medicare payments are made for items and services which are “reasonable and necessary” for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. See Social Security Act §1862(a)(1)(A). Notification is hereby given that you are expected to comply with the prepayment process for claims for all dates and services.

Should you have any questions, please contact me in writing or via telephone at {phone number}.

Sincerely,

Name

D. Payment Suspension Initial Notice Based on Reliable Information (Prior Notice Given)

Date
Name of Addressee (if known)
Name of Medicare Provider/Supplier
Address
City, State Zip

Re: Notice of Suspension of Medicare Payments
Provider/Supplier Medicare ID Number(s):
Provider/Supplier NPI:
PSP Number:

Dear {Medicare Provider/Supplier's Name}:

The purpose of this letter is to notify you of our determination to suspend your Medicare payments {INSERT THE FOLLOWING IF THIS IS A NATIONAL PAYMENT SUSPENSION: in all jurisdictions} pursuant to 42 C.F.R. § 405.371(a)(1). The suspension of your Medicare payments will take effect on {ENTER DATE}. This payment suspension may last for up to 180 days from the effective date and may be extended under certain circumstances. See 42 C.F.R. § 405.372(d). Any delays in producing medical records linked to the payment suspension request will likely extend this period beyond the 180 days.

The decision to suspend your Medicare payments was made by the Centers for Medicare & Medicaid Services (CMS) through its Central Office. The suspension of your Medicare payments is based on reliable information that an overpayment exists or that the payments to be made may not be correct. Specifically, the suspension of your Medicare payments is based on, but not limited to, information from claims data analysis and medical review completed by {NAME OF *UPIC* or MAC.} More particularly, {Continue with further supportive information and specific claim examples (no less than five). Only use claim numbers, Date of Service and amount paid when referencing the claim examples. Do Not use beneficiary names or HIC#s in the notice.}

The following list of sample claims provide evidence of our findings and serve as a basis for the determination to suspend your Medicare payments:

Claim Control Number	Date(s) of Service	$$ Amount Paid

This list is not exhaustive or complete in any sense, as the investigation into this matter is continuing. The information is provided by way of example in order to furnish you with adequate notice of the basis for the payment suspension noticed herein.

Pursuant to 42 C.F.R. § 405.372(b)(2), you have the right to submit a rebuttal statement in writing to us within the next 15 days indicating why you believe the suspension should be removed. You should include with this statement any evidence you believe is pertinent to your reasons why the

suspension should be removed. Your rebuttal statement and any pertinent evidence should be sent to:

Your Name, Program Integrity Analyst
{ADDRESS}

If you submit a rebuttal statement, we will review that statement (and any supporting documentation) along with other materials associated with the case. Based on a careful review of the information you submit and all other relevant information known to us, we will determine whether the suspension should be removed, modified, or should remain in effect within 15 days of receipt of the complete rebuttal package. Thereafter, we will notify you in writing of our determination to continue or remove the suspension and provide specific findings on the conditions upon which the suspension may be continued or removed, as well as an explanatory statement of the determination. See 42 C.F.R. § 405.375(b)(2). However, if by the end of this period no rebuttal has been received, the payment suspension will go into effect automatically. This determination is not administratively appealable. See 42 C.F.R. § 405.375(c).

If the suspension is continued, we will review additional evidence during the suspension period to determine whether claims are payable and/or whether an overpayment exists and, if so, the amount of the overpayment. See 42 C.F.R. § 405.372(c). We may need to contact you with specific requests for further information. You will be informed of developments and will be promptly notified of any overpayment determination. Claims will continue to be processed during the suspension period, and you will be notified about bill/claim determinations, including appeal rights regarding any bills/claims that are denied. The payment suspension applies to both current and future payments.

In the event that an overpayment is determined and it is determined that a recoupment of payments under 42 C.F.R. § 405.371(a)(3) should be put into effect, you will receive a separate written notice of the intention to recoup and the reasons. You will be given an opportunity for rebuttal in accordance with 42 C.F.R. § 405.374 from {MAC name.} When the payment suspension has been removed, any money withheld as a result of this action shall be first be applied to reduce or eliminate the determined overpayment and then to reduce any other obligation to CMS or to the U.S. Department of Health and Human Services in accordance with 42 C.F.R. § 405.372(e). In the absence of a legal requirement that the excess be paid to another entity, the excess will be released to you.

{Insert the following paragraph if prepayment review is being initiated:} Finally, {Name of *UPIC* or MAC}, a CMS {*Unified Program Integrity Contractor (UPIC)* or Medicare Administrative Contractor (MAC)}, has initiated a process to review your Medicare claims and supporting documentation prior to payment. The purpose of implementing this prepayment process is to ensure that all payments made by the Medicare program are appropriate and consistent with Medicare rules, regulations and policy. The prepayment process is often applied to safeguard Medicare from unnecessary expenditures and to ensure that Medicare payments are made for items and services which are "reasonable and necessary" for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. See Social Security Act § 1862(a)(1)(A). Notification is hereby given that you are expected to comply with the prepayment process for claims for all dates and services.

Should you have any questions, please contact me in writing or via telephone at {phone number}.

Sincerely,

Name

E. Reliable Information that an Overpayment Exists (RIO) Payment Suspension Extension Notice

Date
Name of Addressee (if known)
Name of Medicare Provider/Supplier
Address
City, State Zip

Re: Notice of Extension of Suspension of
Medicare Payments Provider/Supplier
Medicare ID Number(s):
Provider/Supplier NPI:
PSP Number:

Dear {Medicare Provider/Supplier's Name}:

Please be advised that pursuant to 42 C.F.R. § 405.372(d), the Centers for Medicare & Medicaid Services (CMS) has directed {ENTER UPIC NAME} to continue the suspension of your Medicare payments for an additional 180 days effective {Enter Date that the payment suspension was to expire}.

The extension of your payment suspension applies to both claims in process and future claims. We will continue to withhold your Medicare payments until an investigation of the circumstances has been completed in accordance with 42 C.F.R. § 405.372(d). When the payment suspension is terminated, any money withheld as a result of this action shall be applied first to reduce or eliminate the determined overpayment and then to reduce any other obligation to CMS or the U.S. Department of Health and Human Services. See 42 C.F.R. §405.372(e). In the absence of a legal requirement that the excess be paid to another entity, the remainder will be released to you.

Should you have any questions, please contact me in writing or by telephone at {phone number}.

Sincerely,

Name

F. Credible Allegation of Fraud (CAF) Payment Suspension Extension Notice

Date
Name of Addressee (if known)
Name of Medicare Provider/Supplier
Address
City, State Zip

Re: Notice of Extension of Suspension of Medicare Payments
Provider/Supplier Medicare ID Number(s):
Provider/Supplier NPI:

PSP Number:

Dear {Medicare Provider/Supplier's Name}:

Please be advised that pursuant to 42 C.F.R. § 405.371(b), the Centers for Medicare & Medicaid Services (CMS) has directed {ENTER *UPIC* NAME} to continue the suspension of your Medicare payments for an additional 180 days effective {Enter Date that the payment suspension was to expire}.

The continuation of your payment suspension applies to both claims in process and future claims. We will continue to suspend your Medicare payments until an investigation of the circumstances has been completed in accordance with 42 C.F.R. § 405.372(c)(2). When the payment suspension is terminated, any money withheld as a result of this action shall be applied first to reduce or eliminate any determined overpayments, including any interest assessed under 42 C.F.R. § 405.378, and then to reduce any other obligation to CMS or the U.S. Department of Health and Human Services. See 42 C.F.R. § 405.372(e). In the absence of a legal requirement that the excess be paid to another entity, the remainder will be released to you.

Should you have any questions, please contact me in writing or by telephone at {phone number}.

Sincerely,

Name

G. Payment Suspension Termination Notice

Date
Name of Addressee (if known)
Name of Medicare Provider/Supplier
Address
City, State Zip

Re: Notice of Termination of Suspension of
Medicare Payments Provider/Supplier
Medicare ID Number(s):
Provider/Supplier NPI:
PSP Number:

Dear {Medicare Provider/Supplier's Name}:

Pursuant to 42 C.F.R. §405.372(c), this is to notify you that the Centers for Medicare & Medicaid Services (CMS) has directed us to terminate the payment suspension in effect for your Medicare payments. You were notified of the results of our review and the overpayment(s) we determined on {Enter Date of letter}. This information has been forwarded to {MAC Name} for final action. In the near future, they will issue the overpayment demand letter, along with information regarding your appeal rights and process. When the payment suspension has been removed, any money withheld as a result of this action shall first be applied to reduce or eliminate any overpayment and then to reduce any obligation to CMS or U.S. Department of Health and Human Services per 42 C.F.R. § 405.372(e). In the absence of a legal requirement that the excess be paid to another entity, the excess will be released to you.

Please be advised that this action to terminate your payment suspension should not be construed as any positive determination regarding your Medicare billing, nor is it an indication of government approval of or acquiescence regarding the claims submitted. It does not relieve you of any civil or criminal liability, nor does it offer a defense to any further administrative, civil or criminal actions against you.

Should you have any questions, please contact me in writing or via telephone at {phone number}.

Sincerely,

Name

Exhibit 25 – Procedures and Forms for Obtaining Protected Health Information

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

Office of the Director

U.S. Department of Justice
Executive Office for United States Attorneys
Room 2616, RFK Main Justice Building
950 Pennsylvania Avenue, NW
Washington, DC 20530
(202) 514-2121

MEMORANDUM -Sent via Electronic Mail

DATE: April 11, 2003

TO: ALL UNITED STATES A TTORNEYS
ALL FIRST ASSISTANT UNITED STATES ATTORNEYS
ALL CRIMINAL CHIEFS
ALL CIVIL CHIEFS

FROM: Guy A. Lewis
Director

SUBJECT: Procedures and Forms for Obtaining Protected Health Information in Law Enforcement and Health Oversight Investigations; Guidance Materials Concerning New HIPAA Privacy Regulations.

ACTION REQUIRED: Please distribute to all Assistant United States Attorneys.

CONTACT PERSONS: Cam Towers Jones
Health Care Fraud Coordinator
Legal Programs
Telephone: (202) 353-8507

Andrea Gross
Affirmative Civil Enforcement Coordinator
Legal Programs

Telephone: (202) 305-3346

New medical privacy rules (located at 45 C.F .R., Parts 160 and 164) take effect on Monday, Apri114, 2003. These rules will affect all Assistant United States Attorneys (AUSAs) who obtain medical information in the course of their work.

In order to assist AUSAs, the Executive Office for United States Attorneys (EOUSA) and the Civil and Criminal Divisions of the Department of Justice have prepared form materials which can be used to obtain medical records in law enforcement and health oversight investigations. Attached is a WordPerfect document titled "Updated Process, Model Letters, and Forms to Request Protected Health Information Pursuant to the HIPAA Privacy Regulation." This document includes (1) a description of the process for obtaining Centers for Medicare and Medicaid Services (CMS) data after Apri114, 2003; (2) a form letter to be used in requesting information from CMS contractors; (3) a form letter to be used in requesting protected health information from entities other than CMS contractors (including federal agencies in affirmative civil and criminal health care fraud cases; and (4) potential paragraphs to be inserted in letters, subpoenas, or other forms of legal process requesting production of protected health information.

EOUSA and the Civil and Criminal Divisions of the Department of Justice have also prepared guidance about the regulation in a "question and answer" format. These guidance materials were distributed at the recent Health Care Fraud Coordinators Conference at the National Advocacy Center. An additional copy is also attached to this memorandum, for your information.

Copies of the documents attached to this memorandum will also be posted on the EOUSA ACEO and Health Care Fraud Web Page at: http://www.usa.doj.gov/staffs/lp/ace/.

If you have any questions regarding implementation of the privacy regulations, you may contact one of the people listed below:

Dan Anderson (Affirmative Civil)
Civil Division
(202) 616-2451

Ian DeWaal (Criminal)
Criminal Division
(202) 514-0669

Jim Gilligan (Civil Defensive/Federal Programs)
Civil Division
(202) 514-3358

Andrea Gross (Affirmative Civil)
Executive Office for United States Attorneys
(202) 305-3346

Cam Towers Jones (Criminal)
Executive Office for United States Attorneys
(202) 353-8507

Sherri Keene (Civil DefensiveIFTCA)
Civil Division
(202) 616-4272

Karen Morrissette (Criminal)
Criminal Division
(202) 514-0640

Attachments

cc: All United States Attorneys' Secretaries

UPDATED PROCESS, MODEL LETTERS AND FORMS TO REQUEST PROTECTED HEALTH INFORMATION PURSUANT TO THE PRIVACY ACT AND HIPAA PRIVACY RULE

Table of Contents

Updated Process for Law Enforcement Agency Requests to Obtain CMS/Medicare Data

1. The law enforcement agency should begin by consulting with the appropriate Medicare contractor (usually the *Unified Program Integrity Contractor*, but possibly also the Carrier, Fiscal Intermediary, Quality Improvement Organization, or CMS) to discuss the purpose or goal of the data request. To illustrate, are data being sought to assess allegations of fraud; examine billing patterns; ascertain dollar losses to the Medicare program for a procedure, service or time period; conduct a random sample of claims for medical review, etc? Upon receiving a data request from a law enforcement agency, the Medicare contractor (e.g., *UPIC*) will examine its sources of data for most recent 36-month period for the substantive matter/s in question or for the specific period requested by the law enforcement agency, if necessary. In consultation with the Medicare contractor, the law enforcement agency also should make known the following:

- type of data and "fields of information" needed
- name and/or other identifying information for provider/s (e.g., Tax Identification Number, Unique Physican Identification Number, etc.)
- time period necessary for the inquiry (approximate begin and end dates if the conduct is not ongoing currently), and
- format or medium for data to be provided (i.e., tape, CD-ROM, paper, etc.).

2. As part of the initial consultation process, the Medicare contractor and law enforcement agency should develop appropriate language to insert in the data request "standard form letter." (A copy of an updated "standard form letter" from the law enforcement agency to Medicare contractor, along with various template paragraphs for insertion in the letter to ensure Privacy Act and HIPAA Privacy Rule compliance, are provided as attachments.) After consulting with the appropriate Medicare contractor, the law enforcement agency should send the signed standard form letter, identifying the appropriate authority under which the information is being sought and specifying the details of the request described above, to the Medicare contractor. The Medicare contractor will provide the relevant data, reports and findings to the requesting agency in the format/s requested within 30 days when data for the most recent 36-month period is being sought directly from the Medicare contractor. If it is necessary for the Medicare contractor to seek and acquire other data from CMS or another affiliated Medicare contractor, the time period required to provide the data to the requesting agency will extend beyond 30 days. (Currently, the average response period for data requests made to CMS is 14 weeks.) [1]

3. If appropriate, the Medicare contractor will also use analytic tools to look for other possible indicia of fraud in addition to the specific alleged conduct that was the cause of the law enforcement agency's data request.

4. If, in the view of the requesting law enforcement agency, the Medicare contractor, or CMS, the Medicare contractor's "initial 36-month review" generally verifies the fraud allegations, or if potential fraud is uncovered through the use of analytic tools, and upon a subsequent request, the Medicare contractor will conduct a supplemental review of Medicare data. The supplemental review will meet the specific needs of the law enforcement agency based on the allegations under investigation and/or findings of the initial 36-month review. Such supplemental reviews may involve retrieving information from original Carrier and/or Fiscal Intermediary data files, as well as the National Claims History (NCH), Common Working File (CWF), or other Medicare data files that may be archived in order to cover the complete time frame involved in the allegations and/or allowed by the statute of limitations. The time period for fulfilling

supplemental data requests will be negotiated on a case-by-case basis between CMS and the law enforcement agency making the data request.

5. While steps 1-4 describe the usual process to be followed for handling law enforcement agency requests for CMS/Medicare data, exceptions to this process will be necessary on a case-by-case basis when the law enforcement agency determines that conducting an initial review of the most recent 36-months of data would not be sufficient. For example, exceptions will be necessary if:

a. The most recent 36 months of data would not be helpful to the investigation because the fraud being investigated is alleged to have occurred prior, or in large part prior to, that period.

b. Changes in the payment system used for the type/s of claims in question cause the most current data to be inappropriate for attempting to verify allegations of possible fraud that occurred under a previous payment system.

c. The purpose of the data request cannot be met using only the most recent 36 months of data (e.g., a statistical sampling plan that requires more than 36 months of data to implement the plan correctly and accurately).

d. Litigation deadlines preclude conducting an initial review followed by a more comprehensive supplemental review.

e. Items 5 a-d are illustrative not exhaustive.

6. Each agency (DOJ, FBI, CMS, etc.) will designate a "contact person" for advising their internal agency components and field offices about this updated process for making data requests to CMS/Medicare contractors, and for resolving any conflicts or disagreements that may occur involving specific requests for information.

USE DEPARTMENT OF JUSTICE LETTERHEAD

[DATE]

If this request for data is made to a *Unified Program Integrity Contractor*, Quality Improvement Organization (QIO), Fiscal Intermediary (FI), or Carrier, address to:

Name of contact person
Name of the *UPIC*, QIO, FI, or Carrier
Address

and send a "cc:" to: Regional Office of the Inspector General
Director, Benefit Integrity and Law Enforcement Liaison, CMS

If this request for data is made to CMS, address to:

Centers for Medicare & Medicaid Services
Office of Financial Management
Program Integrity Group
Director, Benefit Integrity and Law Enforcement Liaison
C3-02-16
7500 Security Blvd
Baltimore, MD 21244

and send a "cc:" to: Regional Office of the Inspector General

Re: Request for disclosure of data in CMS Systems of Records

Dear [insert name]:

This letter is to request your assistance in obtaining CMS data from the [insert file name] on [insert type of data needed and providers for which data is needed] for claims during the following time period: [insert time period]. Please provide this data in [specify format, i.e., CD, tape, disk, paper, etc.] directly to [insert name, address, telephone number, and role of the person in connection with the case].

Instructions to DOJ attorney or investigator filling out letter: INSERT APPROPRIATE PARAGRAPHS FROM THE ALTERNATIVES, ATTACHED, Beginning at page 7.

Additionally, to ensure Privacy Act compliance, CMS has issued and published routine uses authorizing disclosure of data in CMS systems of records for such purposes. See 63 Federal Register 38414, July 16, 1998. The focus of our examination is the following: [insert general description of the nature of the law enforcement or health oversight activity being pursued].

You can be assured that the DOJ will take all appropriate measures to ensure that this data will be maintained and used in compliance with Section VI (Confidentiality Procedures) of the Health Care Fraud and Abuse Control Program Guidelines agreed to by the Attorney General and the Secretary of the Department of Health and Human Services under the Health Insurance Portability and Accountability Act of 1996.

I understand that CMS does not commit to processing my request if the estimated cost of doing so exceeds $200,000, and that a CMS representative will contact me if the estimated cost exceeds that amount. Additionally, I understand that CMS officials may intercede should a DOJ request for CMS data create a substantial resource impact on the data processing capabilities of the CMS Data Center, a Medicare Fiscal Intermediary, Carrier, *Unified Program Integrity Contractor*, QIO, or other contractor. For requests initiated by the FBI or United States Attorney's offices, discussions to resolve such resource issues will be conducted between the appropriate CMS official and the appropriate FBI agent or Assistant United States Attorney (AUSA), or if necessary, the appropriate FBI or AUSA supervisor. For requests initiated by DOJ headquarters, or where regional resolution has been unsuccessful, CMS officials may refer such resource issues to the appropriate DOJ headquarters official.

Thank you for your assistance with this matter. Please call me at [insert phone #] if you have any questions about this request.

Sincerely,

[name, title, and office of DOJ official]

USE DEPARTMENT OF JUSTICE LETTERHEAD
MODIFY AS APPROPRIATE FOR YOUR INVESTIGATION AND FOR THE PARTICULAR RECIPIENT OF THE REQUEST (E.G., SUBPOENAED PERSON)

[DATE]

Re: Request for production of protected health information

Dear [insert name]:

This letter is to request that you produce information/data from [source of records] on [insert type of data/information needed and providers for which information is needed] for claims during the following time period: [insert time period]. Please provide this information/data in [specify format, i.e., CD, tape, disk, paper, etc.] directly to [insert name, address, telephone number, and role of the person in connection with the case.]

Instructions to DOJ attorney or investigator filling out letter: INSERT APPROPRIATE PARAGRAPHS FROM THE ALTERNATIVES, ATTACHED, Beginning at page 7.

Thank you for your assistance with this matter. Please call me at [insert phone #] if you have any questions about this request.

Sincerely,

[name, title, office of DOJ official]

POTENTIAL PARAGRAPHS
TO BE INSERTED IN
LETTERS (OR SUBPOENAS,
ETC)
REQUESTING PRODUCTION OF PROTECTED HEALTH
INFORMATION. PLEASE READ ALL PARAGRAPHS
AND ENSURE THAT YOU HAVE INCLUDED ALL
NECESSARY PROVISIONS.

HEALTH OVERSIGHT

You are requested to produce this information to the Department of Justice in its capacity as a health oversight agency, and this information is necessary to further health oversight activities. 45 C.F.R. 164.512(d); 45 C.F.R. 164.501.

REQUIRED BY LAW

The information sought in this request is required by law to be produced to the Department of Justice, pursuant to_____, (cite the applicable law or reference the legal process that is attached to this document.) Disclosure is therefore permitted under 45 C.F.R. 164.512(a).

(NOTE TO DRAFTER: IF THIS REQUEST ALSO FALLS WITHIN THE PROVISIONS OF 45 C.F.R. 164.512 (c), (e), OR (f). THEN YOU MUST ALSO MEET THE REQUIREMENT OF THAT SUBSECTION AND YOU MUST ALSO ASSERT THAT YOU HAVE MET THAT REQUIREMENT.

IF YOUR "REQUIRED BY LAW" REQUEST IS MADE IN A HEALTH OVERSIGHT CAPACITY, YOU SHOULD ASSERT THIS FACT SO THAT THE RECIPIENT OF THE REQUEST UNDERSTANDS THAT NO ADDITIONAL REQUIREMENTS NEED BE MET. 45 C.F.R. Section 164.512(d)(1))

WHISTLEBLOWERS/VICTIMS OF WORKPLACE CRIME
(See 65 Fed. Reg. 250, page 82492)

This request for information is made to you in your capacity as a whistleblower, described at 45 C.F.R. 164.502(j)(l)(i) as "[an individual who] believes in good faith that the covered entity has engaged in conduct that is unlawful or otherwise violates professional or clinical standards, or that the care, services, or conditions provided by the covered entity potentially endangers one or more patients, workers, or the public. . ." You are requested to produce the information described in Attachment A, hereto, to the Department of Justice in its capacity as a health oversight agency, as permitted by 45 C.F.R. 164.502(j)(l)(ii).

OR

This request for information is made to you in your capacity as a victim of a criminal act and a member of the workforce of a covered entity. You are providing information about the suspected perpetrator of the criminal act, and should limit your disclosure to the following information: a) name and address; b) date and place of birth; c) social security number; d) ABO blood type and Rh factor; e) type of injury; f) date and time of treatment; g) date and time of death; h) distinguishing physical characteristics. This request is made pursuant to 45 C.F.R. 164.502(j)(2).

Disclosures for law enforcement purposes pursuant to
process and as otherwise required by law (45 CFR 164.512(f)(1))

The undersigned hereby represents that this request for protected health information is made by a law enforcement agency [specify agency] for law enforcement purposes and is permitted by 45 CFR 164.512(f)(1) in that:

[INSERT PARAGRAPH (i), (iiA), (iiB), OR (iiC) BELOW]

(i) the disclosure is required by law [specify the law];

OR

(iiA) the disclosure is in compliance with and limited by the relevant requirements of a court order or court-ordered warrant, or a subpoena or summons issued by a judicial officer [attach relevant copies];

OR

(iiB) the disclosure is in compliance with and limited by the relevant requirements of a grand jury subpoena [attach copy];

OR

(iiC) the disclosure is in compliance with and limited by the relevant requirements of an administrative request, including an administrative subpoena or summons, a civil or authorized investigative demand, or similar process authorized by law [attach copy]. The undersigned further represents that the information sought is relevant and material to a legitimate law enforcement inquiry, the request is specific and limited in scope to the extent reasonably practicable in light of the purpose for which the information is sought, and de-identified information could not reasonably be used.

Disclosures of information about victims of crimes for law enforcement purposes in response to a law enforcement request (45 CFR 164.512(f)(3))

The undersigned hereby represents that this request for protected health information is made by a law enforcement agency [specify agency] for law enforcement purposes and is permitted by 45 CFR 164.512(f)(3) in that the requested information is about an individual who is or is suspected to be a victim of a crime and that:

[INSERT PARAGRAPH (i) OR (ii) BELOW]

(i) the individual has agreed to the disclosure [specify manner of agreement and/or attach written evidence of agreement]; (examples at page 23)

OR

(ii) the covered entity is unable to obtain the individual's agreement because of incapacity or other emergency circumstance [specify nature of incapacity or emergency circumstance]. The undersigned law enforcement official represents that: the requested information is needed to determine whether a violation of law by a person other than the victim has occurred, and that such information is not intended to be used against the victim; immediate law enforcement activity which depends upon the disclosure would be materially and adversely affected by waiting until the individual is able to agree to the disclosure. The undersigned further asserts that the circumstances are such that the covered entity, in the exercise of its professional judgment, should determine that the disclosure is in the best interests of the individual.

Disclosures about victims of abuse, neglect or domestic violence (45 C.F.R. 164.512(c))

If the covered entity reasonably believes that the individual (whose personally identifiable health information is requested) is a victim of abuse, neglect or domestic violence, this request for information is permitted by 45 C.F.R. 164.512(c)(1) because the disclosure is to _____, which is a government agency authorized by law to receive reports of such abuse, neglect, or domestic violence, and:

[INSERT PARAGRAPH (i) or (ii) or either (iiiA) or (iiiB) below]

i) the disclosure is required by law [specify the law] and complies with and is limited to the relevant requirements of such law;

OR

ii) the individual has agreed to the disclosure [specify manner of agreement and/or attach written evidence of agreement];

OR, EITHER

iiiA) the disclosure is expressly authorized by statute or regulation, namely, [specify the law] and the covered entity believes the disclosure is necessary to prevent serious harm to the individual or other potential victims;

OR

iiiB) the disclosure is expressly authorized by statute or regulation [specify the law] and the individual is unable to agree because of incapacity [specify nature of incapacity], and the recipient law enforcement or public official authorized to receive the report [specify the agency] hereby represents that the protected health information which is sought is not intended to be used against the individual. The_____[specify agency] further represents that an immediate enforcement activity depends on the disclosure and would be materially and adversely affected by waiting until the individual is able to agree to the disclosure.

Locate and Identify

This request for protected health information is made by a law enforcement agency pursuant to the provisions of 45 C.F.R. 164.512(f)(2) which permit the disclosure of the enumerated limited information for identification and location purposes.

A covered entity is permitted to make a disclosure to a law enforcement officer under this paragraph for the purpose of identifying or locating a suspect, fugitive, material witness or a missing person. The following information may be disclosed: (A) name and address; (B) date and place of birth; (C) social security number; (D) ABO blood type and rh factor; (E) type of injury; (F) date and time of treatment; (G) date and time of death (if applicable); (H) a description of distinguishing physical characteristics, including, height, weight, gender, race, hair and eye color, presence or absence of facial hair (beard or moustache), scars and tattoos.

Decedents

(NOTE: This section of the regulation can only be used to permit a disclosure to a coroner, pursuant to a request by a coroner. Therefore, it will seldom be used in connection with requests in federal investigations, and even in those cases, the request must originate from a coroner.)

This request for protected health information is made by a [coroner] [medical examiner] pursuant to the provisions of 45 C.F.R. 164.512(g) which permit a covered entity to disclose protected health information to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law.

Correctional institutions and other law enforcement custodial situations

This request for protected health information is made by a [correctional institution][law enforcement agency] with lawful custody of [fill in name of prisoner/detainee]. The undersigned represents that the protected health information is necessary for (check all that apply): ( ) the provision of health care to this individual; ( ) the health and safety of this individual or other inmates; ( ) the health and safety of the custodial officers or employees of, or others at, the correctional institution; ( ) the health and safety of this individual and custodial officers, or other persons responsible for transporting this inmate, or this individual's transfer from one institution, facility or setting to another; ( ) law enforcement on the premises of the correctional institution; or ( ) the administration and maintenance of the safety, security, and good order of the correctional institution. The requested disclosure of protected health information is permitted by the provisions of 45 C.F.R. 164.512(k)(5).

Judicial/Administrative

The Department of Justice, through its undersigned representative, requests this information for judicial and administrative proceedings. Consistent with 45 C.F.R. 164.512(e), this request is [Insert one of the following alternatives]:

A. Pursuant to the order of [a court] [an administrative tribunal], and the only information disclosed is the protected health information expressly authorized by the order [attach copy of order where appropriate]; OR

Pursuant to a subpoena, discovery request, or other lawful process, that is not accompanied by a court-order or order of an administrative tribunal, and

Reasonable efforts have been made to ensure that the individual whose information is sought has been given notice of the request by way of a good faith attempt to provide written notice to the individual, as shown by the accompanying documentation [attach copy of notice to individual and affidavit of service]; and

The notice to the individual included sufficient information about the underlying litigation or proceeding to permit the individual to raise an objection to the [court] [administrative tribunal]; and

The time for the individual to raise objections to the [court] [administrative tribunal] has expired, and

No objections were filed, or

All objections filed by the individual have been resolved by the [court] [administrative tribunal] and the disclosures sought are consistent with such resolution.

OR [alternate, if patient has not been given notice]:

Reasonable efforts have been made to secure a qualified protective order that meets the requirements set forth in 45 C.F.R.. 164.512(e)(1)(v), and:

The parties to the underlying dispute which precipitated this request for protected health information have agreed to a qualified protective order and have presented it to the [court] [administrative tribunal] with jurisdiction over the dispute [attach copy of proposed protective order, if appropriate], OR

We have requested a qualified protective order from the [court] [administrative tribunal] with jurisdiction over the dispute [attach copy of proposed protective order, if appropriate].

Minimum Necessary

(NOTE: Do not use this language when the request is authorized by the patient or "required by law", because the "minimum necessary" standard does not apply to disclosures which are required by law." 65 Fed. Reg. 250, 82530, 82600, 82715);
45 C.F.R. 164.502(b)(2)(v)

The information sought in this request is the "minimum necessary to accomplish the intended purpose of the . . . request." 45 C.F.R. 164.502(b)(2)(v). (See 65 Fed. Reg. 82530 "A covered entity is not required to second guess the scope or purpose of the request...")

Insert Only When Suspension of Notification to Individual is Desired

The protected health information concerning the patients

[INSERT EITHER PARAGRAPH (i) OR (ii) BELOW]

(i) listed on Attachment A, hereto, which your organization disclosed to the Department of Justice on_____(specify date) in response to a

OR

(ii) which is disclosed in response to the accompanying

_____ (insert type of request, e.g. grand jury subpoena, other subpoena, oral request, other) was requested in furtherance of a federal_____law enforcement/health oversight (choose one) investigation. An accounting of this disclosure to the individuals concerned would, in this instance, be "reasonably likely to impede the [Department of Justice's] activities " 45 C.F.R. Section 164.528(a)(2)(i). Therefore, pursuant to this request and as required by the provisions of 45 C.F.R. Sec. 164.528(a)(2), you must suspend the individual(s)' right to receive an accounting of this disclosure of protected health information for (months/years).

PATIENT AUTHORIZATIONS

You are requested to release records pertaining to the individual(s) indicated on the enclosed form(s) titled "Authorization to Release Medical Information."

NOTE:

(1) Your state laws may contain medical record release requirements other than those set out on this form.

(2) If psychotherapy notes are requested, please use the separate authorization for this specific purpose. The regulations provide that an authorization for disclosure of psychotherapy notes may only be combined with another authorization for a use or disclosure of psychotherapy notes. 45 CFR 164.508(b)(3)(ii).

PATIENT AUTHORIZATION TO RELEASE MEDICAL INFORMATION

TO:	PATIENT:	RELEASE TO:
[Name of person or class of persons authorized to make disclosure]	NAME: BIRTH DATE:	Representatives of the United States Attorney's Office or Department of Justice

INFORMATION REQUESTED: I request and authorize the above-named person or class of persons to release the information specified below to representatives of the United States Attorney's Office or the Department of Justice. Any and all records regarding treatment of _____ including but not limited to:

(1) Copy of complete chart, progress notes & interview notes, discharge summaries, operative reports, x-ray & all imagery, laboratory tests, pathology tissue, and all diagnostic studies whether in electronic data or other format.

(2) Billing records

PURPOSE(S) OR NEED FOR WHICH INFORMATION IS TO BE USED:

[Include case name or identify administrative claim]

CERTIFICATION: I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this Authorization at any time, provided that revocation is in writing, except to the extent that action has already been taken in reliance this Authorization. I understand that the doctor, health care provider, or health plan from whom my medical information is requested in this Authorization, may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I understand the potential for the information disclosed pursuant to this Authorization to be subject to redisclosure by the recipient and no longer be protected by the Standards for Privacy of Individually Identifiable Health Information, set forth at 45 CFR Parts 160 and 164.

EXPIRATION:

Check one:

__This Authorization will automatically expire upon completion of the litigation [provide case name and number]_____now pending in U.S. District Court for the_____District of_____.

__ This Authorization will automatically expire upon completion of the administrative claim of _____filed on_____.

__ This Authorization shall be effective until_____.

OTHER CONDITIONS:

__x__ A copy of this Authorization or my signature thereon shall be used with the same effectiveness as an original.
__x__ Communications between provider and any representative of the U.S. Attorney's Office/Department of Justice are authorized.

SIGNATURE OF PATIENT:

OR PERSON AUTHORIZED TO SIGN FOR
PATIENT:*_____

_____ _____

MONTH/DAY/YEAR PRINT OR TYPE NAME

*Provide basis of Authorization:____
.

PATIENT AUTHORIZATION TO RELEASE PSYCHOTHERAPY INFORMATION

TO:	PATIENT:	RELEASE TO:
[Name of person or class of persons authorized to make disclosure]	NAME: BIRTH DATE:	Representatives of the United States Attorney's Office or Department of Justice

INFORMATION REQUESTED: I request and authorize the above-named person or class of persons to release the information specified below to representatives of the United States Attorney's Office or the Department of Justice. Any and all records regarding treatment of _____ _____ including but not limited to:

1. All records of psychological or psychiatric testing or treatment, including complete chart, audio and visual recordings, and psychotherapy notes, and

2. Billing records.

PURPOSE(S) OR NEED FOR WHICH INFORMATION IS TO BE USED:

[Include case name or identify administrative claim]

CERTIFICATION: I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this Authorization at any time, provided that revocation is in writing, except to the extent that action has already been taken in reliance this Authorization. I understand that the doctor, health care provider, or health plan from whom my medical information is requested in this Authorization, may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I understand the potential for the information disclosed pursuant to this Authorization to be subject to redisclosure by the recipient and no longer be protected by the Standards for Privacy of Individually Identifiable Health Information, set forth at 45 CFR Parts 160 and 164.

EXPIRATION:

Check one:

__This Authorization will automatically expire upon completion of the litigation [provide case name and number]_____now pending in U.S. District Court for the_____District of_____.

This Authorization will automatically expire upon completion of the administrative claim of _____ filed on____.

__ This Authorization shall be effective until_____.

OTHER CONDITIONS:

__x__ A copy of this Authorization or my signature thereon shall be used with the same effectiveness as an original.
__x__ Communications between provider and any representative of the U.S. Attorney's Office/Department of Justice are authorized.

SIGNATURE OF PATIENT:

OR PERSON AUTHORIZED TO SIGN FOR PATIENT:*_____

_____ _____

MONTH/DAY/YEAR PRINT OR TYPE NAME

*Provide basis of Authorization:_____.

Exhibit 36.1 - CERT Formats for A/B MAC (A) MACS and Shared Systems

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

Claims Universe File
Claims Universe Header Record (one record per file)

Field Name	Picture	From	Thru	Initialization
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	'1'
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Universe Date	X(8)	9	16	Spaces

DATA ELEMENT DETAIL

Data Element: Contractor ID
Definition: Contractor's CMS assigned number
Validation: Must be a valid CMS contractor ID
Remarks: N/A
Requirement: Required
NOTE: For A/B MAC (A) and A/B MAC (HHH), when multiple workloads share a single processing environment, the Contractor ID will reflect the roll-up Contractor ID specified by CMS

Data Element: Record Type
Definition: Code indicating type of record
Validation: N/A
Remarks: 1 = Header record
Requirement: Required

Data Element: Record Version Code
Definition: The code indicating the record version of the Claim Universe file
Validation: Claim Universe files prior to 10/1/2007 did not contain this field.
Codes:
B = Record Format as of 10/1/2007
C = Record Format as of 10/1/2017
Remarks: N/A
Requirement: Required

Data Element: Contractor Type
Definition: Type of Medicare Contractor included in the file
Validation: Must be 'A' or 'R'
Where the TYPE of BILL, 1st position = 3, Contractor Type should be 'R'.
Where the TYPE of BILL, 1st/2nd positions = 81 or 82, contractor Type should be 'R'.
All others will be contractor type 'A'.
Remarks: A = A/B MAC (A) only
R = A/B MAC (HHH) only or both A/B MAC (A) and A/B MAC (HHH)
Requirement: Required

Data Element: Universe Date
Definition: Date the universe of claims entered the shared system
Validation: Must be a valid date not equal to a universe date sent on any previous claims universe file
Remarks: Format is CCYYMMDD. May use shared system batch processing date; however, the Universe Date must not equal the universe date on any previous claims universe file.
Requirement: Required

Claims Universe File
Claims Universe Claim Record

Field Name	Picture	From	Thru	Initialization
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	"2"
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Internal Control Number	X(23)	9	31	Spaces
Beneficiary HICN	X(12)	32	43	Spaces
Billing Provider Number	X(9)	44	52	Spaces
Billing Provider NPI	X(10)	53	62	Spaces
Type of Bill	X(3)	63	65	Spaces
Claim From Date	X (8)	66	73	Spaces
Claim Through Date	X (8)	74	81	Spaces
Condition Code 1	X (2)	82	83	Spaces

Field Name	Picture	From	Thru	Initialization
Condition Code 2	X (2)	84	85	Spaces
Condition Code 3	X (2)	86	87	Spaces
Condition Code 4	X (2)	88	89	Spaces
Condition Code 5	X (2)	90	91	Spaces
Condition Code 6	X (2)	92	93	Spaces
Condition Code 7	X (2)	94	95	Spaces
Condition Code 8	X (2)	96	97	Spaces
Condition Code 9	X (2)	98	99	Spaces
Condition Code 10	X (2)	100	101	Spaces
Condition Code 11	X (2)	102	103	Spaces
Condition Code 12	X (2)	104	105	Spaces
Condition Code 13	X (2)	106	107	Spaces
Condition Code 14	X (2)	108	109	Spaces
Condition Code 15	X (2)	110	111	Spaces
Condition Code 16	X (2)	112	113	Spaces
Condition Code 17	X (2)	114	115	Spaces
Condition Code 18	X (2)	116	117	Spaces
Condition Code 19	X (2)	118	119	Spaces
Condition Code 20	X (2)	120	121	Spaces
Condition Code 21	X (2)	122	123	Spaces
Condition Code 22	X (2)	124	125	Spaces
Condition Code 23	X (2)	126	127	Spaces
Claim Demonstration Number	X(2)	128	129	Spaces
PPS Indicator Code	X(1)	130	130	Spaces
Claim State	X(2)	131	132	Spaces
Beneficiary State	X(2)	133	134	Spaces
Claim Total Charge Amount	9(8)V99	135	144	Zeroes
Beneficiary MBI	X(11)	145	155	Spaces
Hicn/MBI indicator	X(1)	156	156	Spaces
Filler	X(2)	157	158	Spaces
Revenue Code Count	9(3)	159	161	Zero

Claims Universe File

Claims Universe Revenue Code Group (Claim Line Items)

*The following group of fields occurs from 1 to 450 times (depending on Revenue Code Count)

*From and Thru values relate to the 1st line item

Field Name	Picture	From	Thru	Initialization
Revenue Center Code	X(4)	162	165	Spaces
HCPCS	X(5)	166	170	Spaces
Revenue Center Total Charge	9(8)V99	171	180	Zeroes

DATA ELEMENT DETAIL

Claim (Header) Fields

Data Element: Contractor ID

Definition: Contractor's CMS assigned number
Validation: Must be a valid CMS contractor ID
Remarks: N/A
Requirement: Required
NOTE: For A/B MAC (A) and A/B MAC (HHH), when multiple workloads share a single processing environment, the Contractor ID will reflect the roll-up Contractor ID specified by CMS

Data Element: Record Type
Definition: Code indicating type of record
Validation: N/A
Remarks: 2 = claim record
Requirement: Required

Data Element: Record Version Code
Definition: The code indicating the record version of the Claim Universe file
Validation: Claim Universe files prior to 10/1/2007 did not contain this field.
Codes:
B = Record Format as of 10/1/2007
C = Record Format as of 10/1/2017
Remarks: N/A
Requirement: Required

Data Element: Contractor Type
Definition: Type of Medicare Contractor included in the file
Validation: Must be 'A' or 'R'.
Where the TYPE of BILL, 1st position = 3, Contractor Type should be 'R'.
Where the TYPE of BILL, 1st/2nd positions = 81 or 82, contractor Type should be 'R'.
All others will be contractor type 'A'.

Data Element: Internal Control Number
Definition: Number assigned by the shared system to uniquely identify the claim
Validation: N/A
Remarks: Do not include hyphens or spaces
Requirement: Required

Data Element: Beneficiary HICN
Definition: Beneficiary's Health Insurance Claim Number
Validation: N/A
Remarks: Do not include hyphens or spaces
Requirement: Required

Data Element: Billing Provider Number
Definition: First nine characters of number assigned by Medicare to identify the billing/pricing provider or supplier.
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: Billing Provider NPI

Definition: NPI assigned to the Billing Provider.
Validation: N/A
Remarks: N/A.
Requirement: Required by May 23, 2007 for claims using HIPAA standard Transactions

Data Element: Type of Bill
Definition: Three-digit alphanumeric code gives three specific pieces of information. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this bill in this particular episode of care. It is referred to as "frequency" code.
Validation: Must be a valid code as listed in Pub 100-4, Medicare Claims Processing Manual, Chapter 25, Completing and Processing CMS-1450 Data Set.
Remarks: N/A
Requirement: Required

Data Element: Claim from Date
Definition: The first day on the billing statement covering services rendered to the beneficiary.
Validation: Must be a valid date
Remarks: Format is CCYYMMDD
Requirement: Required

Data Element: Claim through Date
Definition: The last day on the billing statement covering services rendered to the beneficiary.
Validation: Must be a valid date
Remarks: Format is CCYYMMDD
Requirement: Required

Data Element: Condition Code 1
Condition Code 2
Condition Code 3
Condition Code 4
Condition Code 5
Condition Code 6
Condition Code 7
Condition Code 8
Condition Code 9
Condition Code 10
Condition Code 11
Condition Code 12
Condition Code 13
Condition Code 14
Condition Code 15
Condition Code 16
Condition Code 17
Condition Code 18
Condition Code 19
Condition Code 20
Condition Code 21
Condition Code 22
Condition Code 23

Definition: The code that indicates a condition relating to an institutional claim that may affect payer processing.
Validation: Must be a valid code as defined in the Claims Processing Manual (Pub. 100-4) chapter 25 (Completing and Processing CMS-1450 Data Set).
Remarks: N/A
Requirement: Required if claim has a condition code

Data Element: Claim Demonstration Identification Number
Definition: The number assigned to identify a demonstration Project. This field is also used to denote special processing (a.k.a. Special Processing Number, SPN).
Validation: Must be a Valid Demo ID.
Remarks: N/A
Requirement: Required when available on claim

Data Element: PPS Indicator Code alias Claim PPS Indicator Code
Definition: The code indicating whether (1) the claim is Prospective Payment System (PPS), (2) Unknown or (0) not PPS.
Validation: 0 = Not PPS
1 = PPS
2 = Unknown
Remarks: N/A
Requirement: Required

Data Element: Claim State
Definition: 2 character abbreviation identifying the state in which the service is furnished
Validation: Must be a valid 2 digit state abbreviation as defined by the United States Postal Service (USPS) or blank.
Remarks: N/A
Requirement: Required if on claim record

Data Element: Beneficiary State
Definition: 2 character abbreviation designating the state in which the beneficiary resides.
Validation: Must be a valid 2 digit state abbreviation as defined by the United States Postal Service (USPS) or blank.
Remarks: N/A
Requirement: Required if on claim record

Data Element: Claim Total Charge Amount
Definition: The total charges for all services included on the institutional claim.
Validation: N/A
Remarks: This field should contain the same amount as revenue center code 0001/total charges.
Requirement: Required

Data Element: Beneficiary MBI
Definition: Beneficiary's Medicare Beneficiary Identifier
Validation: Comply with CMS Standards

- 11-character, fixed length alpha-numeric string
- Different, visibly distinguishable from HICN/RRB numbers
- Contain no more than 2 consecutive numbers
- Contain no more than 2 consecutive alphabetic characters

- Must limit the possibility of letters being interpreted as numbers (i.e., alphabetic characters [A…Z]; excluding S, L, O, I, B, Z)
- Must not contain lowercase letters
- Must not contain any special characters

Remarks: Do not include hyphens or spaces
Requirement: Required, when available

Data Element: HICN/MBI Indicator
Definition: Indicator that identifies if the provider submitted the claim with a HICN or MBI
Validation: M = MBI submitted on the claim
H = HICN submitted on the claim
Remarks: N/A
Requirement: Required

Data Element: Revenue Code Count
Definition: Number indicating number of revenue code lines on the claim. Include line 1 in the count.
Validation: Must be a number 01 – 450
Remarks: N/A
Requirement: Required

Claim Line Item Fields

Data Element: Revenue Code
Definition: Code assigned to each cost center for which a charge is billed.
Validation: Must be a valid National Uniform Billing Committee (NUBC) approved code.
Remarks: Include an entry for revenue code '0001'.
Requirement: Required

Data Element: HCPCS Procedure Code or HIPPS Code
Definition: The HCPCS/CPT-4 code that describes the service or Health Insurance PPS (HIPPS) code.
Validation: Must be a valid HCPCS/CPT-4 code.
Remarks: Healthcare Common Procedure Coding System (HCPCS) is a collection of codes that represent procedures, supplies, products and services which may be provided to Medicare beneficiaries and to individuals enrolled in private health insurance programs.

When revenue center code = '0022' (SNF PPS), '0023' (HH PPS), or '0024' (IRF PPS); this field contains the Health Insurance PPS (HIPPS) code.

The HIPPS code for SNF PPS contains the rate code/assessment type that identifies RUG-III group the beneficiary was classified into as of the RAI MDS assessment reference date and (2) the type of assessment for payment purposes.

The HIPPS code for Home Health PPS identifies (1) the three case-mix dimensions of the HHRG system, clinical, functional and utilization, from which a beneficiary is assigned to one of the 80 HHRG categories and (2) it identifies whether or not the elements of the code were computed or derived. The HHRGs, represented by the HIPPS coding, will be the basis of payment for each episode.

The HIPPS code (CMG Code) for IRF PPS identifies the clinical characteristics of the beneficiary. The HIPPS rate/CMG code (AXXYY - DXXYY) must contain five digits. The first position of the code is an A, B, C, or 'D'. The HIPPS code beginning with an 'A' in front of the CMG is defined as without co-morbidity. The 'B' in front of the CMG is defined as with co-morbidity for Tier 1. The 'C' is defined as co-morbidity for Tier 2 and 'D' is defined as co-morbidity for Tier 3. The 'XX' in the HIPPS rate code is the Rehabilitation Impairment Code (RIC). The 'YY' is the sequential number system within the RIC.

Requirement: Required if present on bill

Data Element: Revenue Center Total Charge

Definition: The total charges (covered and non-covered) for all accommodations and services (related to the revenue code) for a billing period before reduction for the deductible and coinsurance amounts and before an adjustment for the cost of services provided

Validation: N/A
Remarks: N/A
Requirement: Required

Claims Universe File
Claims Universe Trailer Record (one record per file)

Field Name	Picture	From	Thru	Initialization
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	'3'
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Number of Claims	9(9)	9	17	Zeroes

DATA ELEMENT DETAIL

Data Element: Contractor ID
Definition: Contractor's CMS assigned number
Validation: Must be a valid CMS contractor ID
Remarks: N/A
Requirement: Required
NOTE: For A/B MAC (A) and A/B MAC (HHH), when multiple workloads share a single processing environment, the Contractor ID will reflect the roll-up Contractor ID specified by CMS.

Data Element: Record Type
Definition: Code indicating type of record
Validation: N/A
Remarks: 3=Trailer Record
Requirement: Required

Data Element: Record Version Code

Definition: The code indicating the record version of the Claim Universe file
Validation: Claim Universe files prior to 10/1/2007 did not contain this field.
Codes: B = Record Format as of 10/1/2007
C = Record Format as of 10/1/2017
Remarks: N/A
Requirement: Required

Data Element: Contractor Type
Definition: Type of Medicare Contractor included in the file.
Validation: Must be 'A' or 'R'
Where the TYPE of BILL, 1st position = 3, Contractor Type should be 'R'.
Where the TYPE of BILL, 1st/2nd positions = 81 or 82, contractor Type should be 'R'.
All others will be contractor type 'A'.
Remarks: A = A/B MAC (A) only.
R = A/B MAC (HHH) only or both A/B MAC (A) and A/B MAC (HHH).
Requirement: Required

Data Element: Number of Claims
Definition: Number of claim records on this file
Validation: Must be equal to the number of claim records on the file.
Remarks: Do not count header or trailer records
Requirement: Required

Claims Transaction File
Claims Transaction Header Record (one record per file)

Field Name	Picture	From	Thru	Initialization
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	'1'
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Transaction Date	X(8)	9	16	Spaces

DATA ELEMENT DETAIL

Data Element: Contractor ID
Definition: Contractor's CMS assigned number.
Validation: Must be a valid CMS contractor ID.
Remarks: N/A
Requirement: Required
NOTE: For A/B MAC (A) and A/B MAC (HHH), when multiple workloads share a single processing environment, the Contractor ID will reflect the roll-up Contractor ID specified by CMS.

Data Element: Record Type
Definition: Code indicating type of record
Validation: N/A
Remarks: 1 = Header record
Requirement: Required

Data Element: Record Version Code
Definition: The code indicating the record version of the Claim Transaction file.
Validation: Claim Transaction files prior to 10/1/2007 did not contain this field.
Codes:
B = Record Format as of 10/1/2007
Remarks: N/A
Requirement: Required

Data Element: Contractor Type
Definition: Type of Medicare Contractor included in the file
Validation: Must be 'A' or 'R'
Where the TYPE of BILL, 1st position = 3, Contractor Type should be 'R'.
Where the TYPE of BILL, 1st/2nd positions = 81 or 82, contractor Type should be 'R'.
All others will be contractor type 'A'.

Remarks: A = A/B MAC (A) only
R = A/B MAC (HHH) only or both A/B MAC (A) and A/B MAC (HHH)
Requirement: Required

Data Element: Transaction Date
Definition: Date the Transaction file was created
Validation: Must be a valid date not equal to a Transaction date sent on any previous claims Transaction file.
Remarks: Format is CCYYMMDD. May use shared system batch processing date.
Requirement: Required

Sampled Claims Transaction File
Sampled Claims Transaction File Detail Record

Field Name	Picture	From	Thru	Initialization
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	'2'
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Claim Control Number	X(23)	9	31	Spaces
Beneficiary HICN	X(12)	32	43	Spaces

DATA ELEMENT DETAIL

Data Element: Contractor ID
Definition: Contractor's CMS assigned number
Validation: Must be a valid CMS contractor ID
Remarks: N/A
Requirement: Required
NOTE: For A/B MAC (A) and A/B MAC (HHH), when multiple workloads share a single processing environment, the Contractor ID will reflect the roll-up Contractor ID specified by CMS.

Data Element: Record Type

Definition: Code indicating type of record
Validation: N/A
Remarks: 2 = claim record
Requirement: Required

Data Element: Record Version Code
Definition: The code indicating the record version of the Claim Universe file
Validation: Claim Universe files prior to 10/1/2007 did not contain this field.
Codes:
B = Record Format as of 10/1/2007
Remarks: N/A
Requirement: Required

Data Element: Contractor Type
Definition: Type of Medicare Contractor included in the file
Validation: Must be 'A' or 'R'
Where the TYPE of BILL, 1st position = 3, Contractor Type should be 'R'.
Where the TYPE of BILL, 1st/2nd positions = 81 or 82, contractor Type should be 'R'.
All others will be contractor type 'A'.

Data Element: Claim Control Number
Definition: Number assigned by the shared system to uniquely identify the claim
Validation: N/A
Remarks: Reflects the Claim Control Number selected from the Claim Universe file in the sampling process.
Requirement: Required

Data Element: Beneficiary HICN
Definition: Beneficiary's Health Insurance Claim Number
Validation: N/A
Remarks: Reflects the Beneficiary HICN on the claim record selected from the Claim Universe file in the sampling process.
Requirement: Required

Claims Transaction File
Claims Transaction Trailer Record (one record per file)

Field Name	Picture	From	Thru	Initialization
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	'3'
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Number of Claims	9(9)	9	17	Zeroes

DATA ELEMENT DETAIL

Data Element: Contractor ID
Definition: Contractor's CMS assigned number

Validation: Must be a valid CMS contractor ID
Remarks: N/A
Requirement: Required
NOTE: For A/B MAC (A) and A/B MAC (HHH), when multiple workloads share a single processing environment, the Contractor ID will reflect the roll-up Contractor ID specified by CMS.

Data Element: Record Type
Definition: Code indicating type of record
Validation: N/A
Remarks: 1 = Header record
Requirement: Required

Data Element: Record Version Code
Definition: The code indicating the record version of the Claim Universe file
Validation: Claim Universe files prior to 10/1/2007 did not contain this field.
Codes:
B = Record Format as of 10/1/2007
Remarks: N/A
Requirement: Required

Data Element: Contractor Type
Definition: Type of Medicare Contractor included in the file
Validation: Must be 'A' or 'R'.
Where the TYPE of BILL, 1st position = 3, Contractor Type should be 'R'.
Where the TYPE of BILL, 1st/2nd positions = 81 or 82, contractor Type should be 'R'.
All others will be contractor type 'A'.
Remarks: A = A/B MAC (A) only
R = A/B MAC (HHH) only or both A/B MAC (A) and A/B MAC (HHH)
Requirement: Required

Data Element: Number of Claims
Definition: Number of claim records on this file
Validation: Must be equal to the number of claim records on the file
Remarks: Do not count header or trailer records
Requirement: Required

Claims Resolution File
Claims Resolution Header Record (one record per file)

Field Name	Picture	From	Thru	Initialization
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	'1'
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Resolution Date	X(8)	9	16	Spaces

DATA ELEMENT DETAIL

Data Element: Contractor ID

Definition: Contractor's CMS assigned number
Validation: Must be a valid CMS contractor ID
Remarks: N/A
Requirement: Required
NOTE: For A/B MAC (A) and A/B MAC (HHH), when multiple workloads share a single processing environment, the Contractor ID will reflect the roll-up Contractor ID specified by CMS

Data Element: Record Type
Definition: Code indicating type of record
Validation: N/A
Remarks: 1 = Header record
Requirement: Required

Data Element: Record Version Code
Definition: The code indicating the record version of the Claim Resolution file
Validation: Claim Resolution files prior to 10/1/2007 did not contain this field.
Codes:
B = Record Format as of 10/1/2007
C = Record Format as of 1/1/2010
D = Record Format as of 10/1/2012
E = Record Format as of 7/1/2016
F = Record Format as of 10/1/2017
Remarks: N/A
Requirement: Required

Data Element: Contractor Type
Definition: Type of Medicare Contractor included in the file
Validation: Must be 'A' or 'R'
Where the TYPE of BILL, 1st position = 3, Contractor Type should be 'R'.
Where the TYPE of BILL, 1st/2nd positions = 81 or 82, contractor Type should be 'R'.
All others will be contractor type 'A'.
Remarks: A = A/B MAC (A) only
R = A/B MAC (HHH) only or both A/B MAC (A) and A/B MAC (HHH)
Requirement: Required

Data Element: Resolution Date
Definition: Date the Resolution Record was created.
Validation: Must be a valid date not equal to a Resolution date sent on any previous claims Resolution file
Remarks: Format is CCYYMMDD. May use shared system batch processing date
Requirement: Required

Sampled Claims Resolution File
Sampled Claims Resolution Claim Detailed Record

Field Name	Picture	From	Thru	Initialization
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	"2"

Field Name	Picture	From	Thru	Initialization
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Record Number	9(1)	9	9	Zero
Mode of Entry Indicator	X(1)	10	10	Space
Original Claim Control Number	X(23)	11	33	Spaces
Internal Control Number	X(23)	34	56	Spaces
Beneficiary HICN	X(12)	57	68	Spaces
Beneficiary Last Name	X(60)	69	128	Spaces
Beneficiary First Name	X(35)	129	163	Spaces
Beneficiary Middle Initial	X(1)	164	164	Spaces
Beneficiary Date of Birth	X(8)	165	172	Spaces
Beneficiary Gender	X(1)	173	173	Spaces
Billing Provider Number	X(9)	174	182	Spaces
Attending Physician UPIN	X(6)	183	188	Spaces
Claim Paid Amount	S9(8)V99	189	198	Zeroes
Claim ANSI Reason Code 1	X(8)	199	206	Spaces
Claim ANSI Reason Code 2	X(8)	207	214	Spaces
Claim ANSI Reason Code 3	X(8)	215	222	Spaces
Claim ANSI Reason Code 4	X(8)	223	230	Spaces
Claim ANSI Reason Code 5	X(8)	231	238	Spaces
Claim ANSI Reason Code 6	X(8)	239	246	Spaces
Claim ANSI Reason Code 7	X(8)	247	254	Spaces
Statement covers From Date	X(8)	255	262	Spaces
Statement covers Thru Date	X(8)	263	270	Spaces
Claim Entry Date	X(8)	271	278	Spaces
Claim Adjudicated Date	X(8)	279	286	Spaces
Condition Code 1	X(3)	287	289	Spaces
Condition Code 2	X(3)	290	292	Spaces
Condition Code 3	X(3)	293	295	Spaces
Condition Code 4	X(3)	296	298	Spaces
Condition Code 5	X(3)	299	301	Spaces
Condition Code 6	X(3)	302	304	Spaces
Condition Code 7	X(3)	305	307	Spaces
Condition Code 8	X(3)	308	310	Spaces
Condition Code 9	X(3)	311	313	Spaces
Condition Code 10	X(3)	314	316	Spaces
Condition Code 11	X(3)	317	319	Spaces
Condition Code 12	X(3)	320	322	Spaces
Condition Code 13	X(3)	323	325	Spaces
Condition Code 14	X(3)	326	328	Spaces
Condition Code 15	X(3)	329	331	Spaces
Condition Code 16	X(3)	332	334	Spaces
Condition Code 17	X(3)	335	337	Spaces
Condition Code 18	X(3)	338	340	Spaces
Condition Code 19	X(3)	341	343	Spaces
Condition Code 20	X(3)	344	346	Spaces
Condition Code 21	X(3)	347	349	Spaces
Condition Code 22	X(3)	350	352	Spaces

Field Name	Picture	From	Thru	Initialization
Condition Code 23	X(3)	353	355	Spaces
Condition Code 24	X(3)	356	358	Spaces
Condition Code 25	X(3)	359	361	Spaces
Condition Code 26	X(3)	362	364	Spaces
Condition Code 27	X(3)	365	367	Spaces
Condition Code 28	X(3)	368	370	Spaces
Condition Code 29	X(3)	371	373	Spaces
Condition Code 30	X(3)	374	376	Spaces
Type of Bill	X(3)	377	379	Spaces
Principal Diagnosis Code	X(7)	380	386	Spaces
Other Diagnosis Code 1	X(7)	387	393	Spaces
Other Diagnosis Code 2	X(7)	394	400	Spaces
Other Diagnosis Code 3	X(7)	401	407	Spaces
Other Diagnosis Code 4	X(7)	408	414	Spaces
Other Diagnosis Code 5	X(7)	415	421	Spaces
Other Diagnosis Code 6	X(7)	422	428	Spaces
Other Diagnosis Code 7	X(7)	429	435	Spaces
Other Diagnosis Code 8	X(7)	436	442	Spaces
Other Diagnosis Code 9	X(7)	443	449	Spaces
Other Diagnosis Code 10	X(7)	450	456	Spaces
Other Diagnosis Code 11	X(7)	457	463	Spaces
Other Diagnosis Code 12	X(7)	464	470	Spaces
Other Diagnosis Code 13	X(7)	471	477	Spaces
Other Diagnosis Code 14	X(7)	478	484	Spaces
Other Diagnosis Code 15	X(7)	485	491	Spaces
Other Diagnosis Code 16	X(7)	492	498	Spaces
Other Diagnosis Code 17	X(7)	499	505	Spaces
Other Diagnosis Code 18	X(7)	506	512	Spaces
Other Diagnosis Code 19	X(7)	513	519	Spaces
Other Diagnosis Code 20	X(7)	520	526	Spaces
Other Diagnosis Code 21	X(7)	527	533	Spaces
Other Diagnosis Code 22	X(7)	534	540	Spaces
Other Diagnosis Code 23	X(7)	541	547	Spaces
Other Diagnosis Code 24	X(7)	548	554	Spaces
Principal Diagnosis Code Version Indicator Code	X(1)	555	555	Spaces
Other Diagnosis Code 1 Version Indicator Code	X(1)	556	556	Spaces
Other Diagnosis Code 2 Version Indicator Code	X(1)	557	557	Spaces
Other Diagnosis Code 3 Version Indicator Code	X(1)	558	558	Spaces
Other Diagnosis Code 4 Version Indicator Code	X(1)	559	559	Spaces
Other Diagnosis Code 5 Version Indicator Code	X(1)	560	560	Spaces
Other Diagnosis Code 6 Version Indicator Code	X(1)	561	561	Spaces

Field Name	Picture	From	Thru	Initialization
Other Diagnosis Code 7 Version Indicator Code	X(1)	562	562	Spaces
Other Diagnosis Code 8 Version Indicator Code	X(1)	563	563	Spaces
Other Diagnosis Code 9 Version Indicator Code	X(1)	564	564	Spaces
Other Diagnosis Code 10 Version Indicator Code	X(1)	565	565	Spaces
Other Diagnosis Code 11 Version Indicator Code	X(1)	566	566	Spaces
Other Diagnosis Code 12 Version Indicator Code	X(1)	567	567	Spaces
Other Diagnosis Code 13 Version Indicator Code	X(1)	568	568	Spaces
Other Diagnosis Code 14 Version Indicator Code	X(1)	569	569	Spaces
Other Diagnosis Code 15 Version Indicator Code	X(1)	570	570	Spaces
Other Diagnosis Code 16 Version Indicator Code	X(1)	571	571	Spaces
Other Diagnosis Code 17 Version Indicator Code	X(1)	572	572	Spaces
Other Diagnosis Code 18 Version Indicator Code	X(1)	573	573	Spaces
Other Diagnosis Code 19 Version Indicator Code	X(1)	574	574	Spaces
Other Diagnosis Code 20 Version Indicator Code	X(1)	575	575	Spaces
Other Diagnosis Code 21 Version Indicator Code	X(1)	576	576	Spaces
Other Diagnosis Code 22 Version Indicator Code	X(1)	577	577	Spaces
Other Diagnosis Code 23 Version Indicator Code	X(1)	578	578	Spaces
Other Diagnosis Code 24 Version Indicator Code	X(1)	579	579	Spaces
Principal Procedure	X(7)	580	586	Spaces
Principal Procedure Date	X(8)	587	594	Spaces
Other Procedure 1	X(7)	595	601	Spaces
Other Procedure 1 Date	X(8)	602	609	Spaces
Other Procedure 2	X(7)	610	616	Spaces
Other Procedure 2 Date	X(8)	617	624	Spaces
Other Procedure 3	X(7)	625	631	Spaces
Other Procedure 3 Date	X(8)	632	639	Spaces
Other Procedure 4	X(7)	640	646	Spaces
Other Procedure 4 Date	X(8)	647	654	Spaces
Other Procedure 5	X(7)	655	661	Spaces
Other Procedure 5 Date	X(8)	662	669	Spaces
Other Procedure 6	X(7)	670	676	Spaces

Field Name	Picture	From	Thru	Initialization
Other Procedure 6 Date	X(8)	677	684	Spaces
Other Procedure 7	X(7)	685	691	Spaces
Other Procedure 7 Date	X(8)	692	699	Spaces
Other Procedure 8	X(7)	700	706	Spaces
Other Procedure 8 Date	X(8)	707	714	Spaces
Other Procedure 9	X(7)	715	721	Spaces
Other Procedure 9 Date	X(8)	722	729	Spaces
Other Procedure 10	X(7)	730	736	Spaces
Other Procedure 10 Date	X(8)	737	744	Spaces
Other Procedure 11	X(7)	745	751	Spaces
Other Procedure 11 Date	X(8)	752	759	Spaces
Other Procedure 12	X(7)	760	766	Spaces
Other Procedure 12 Date	X(8)	767	774	Spaces
Other Procedure 13	X(7)	775	781	Spaces
Other Procedure 13 Date	X(8)	782	789	Spaces
Other Procedure 14	X(7)	790	796	Spaces
Other Procedure 14 Date	X(8)	797	804	Spaces
Other Procedure 15	X(7)	805	811	Spaces
Other Procedure 15 Date	X(8)	812	819	Spaces
Other Procedure 16	X(7)	820	826	Spaces
Other Procedure 16 Date	X(8)	827	834	Spaces
Other Procedure 17	X(7)	835	841	Spaces
Other Procedure 17 Date	X(8)	842	849	Spaces
Other Procedure 18	X(7)	850	856	Spaces
Other Procedure 18 Date	X(8)	857	864	Spaces
Other Procedure 19	X(7)	865	871	Spaces
Other Procedure 19 Date	X(8)	872	879	Spaces
Other Procedure 20	X(7)	880	886	Spaces
Other Procedure 20 Date	X(8)	887	894	Spaces
Other Procedure 21	X(7)	895	901	Spaces
Other Procedure 21 Date	X(8)	902	909	Spaces
Other Procedure 22	X(7)	910	916	Spaces
Other Procedure 22 Date	X(8)	917	924	Spaces
Other Procedure 23	X(7)	925	931	Spaces
Other Procedure 23 Date	X(8)	932	939	Spaces
Other Procedure 24	X(7)	940	946	Spaces
Other Procedure 24 Date	X(8)	947	954	Spaces
Principal Procedure Version Indicator Code	X(1)	955	955	Spaces
Other Procedure 1 Version Indicator Code	X(1)	956	956	Spaces
Other Procedure 2 Version Indicator Code	X(1)	957	957	Spaces
Other Procedure 3 Version Indicator Code	X(1)	958	958	Spaces
Other Procedure 4 Version Indicator Code	X(1)	959	959	Spaces

Field Name	Picture	From	Thru	Initialization
Other Procedure 5 Version Indicator Code	X(1)	960	960	Spaces
Other Procedure 6 Version Indicator Code	X(1)	961	961	Spaces
Other Procedure 7 Version Indicator Code	X(1)	962	962	Spaces
Other Procedure 8 Version Indicator Code	X(1)	963	963	Spaces
Other Procedure 9 Version Indicator Code	X(1)	964	964	Spaces
Other Procedure 10 Version Indicator Code	X(1)	965	965	Spaces
Other Procedure 11 Version Indicator Code	X(1)	966	966	Spaces
Other Procedure 12 Version Indicator Code	X(1)	967	967	Spaces
Other Procedure 13 Version Indicator Code	X(1)	968	968	Spaces
Other Procedure 14 Version Indicator Code	X(1)	969	969	Spaces
Other Procedure 15 Version Indicator Code	X(1)	970	970	Spaces
Other Procedure 16 Version Indicator Code	X(1)	971	971	Spaces
Other Procedure 17 Version Indicator Code	X(1)	972	972	Spaces
Other Procedure 18 Version Indicator Code	X(1)	973	973	Spaces
Other Procedure 19 Version Indicator Code	X(1)	974	974	Spaces
Other Procedure 20 Version Indicator Code	X(1)	975	975	Spaces
Other Procedure 21 Version Indicator Code	X(1)	976	976	Spaces
Other Procedure 22 Version Indicator Code	X(1)	977	977	Spaces
Other Procedure 23 Version Indicator Code	X(1)	978	978	Spaces
Other Procedure 24 Version Indicator Code	X(1)	979	979	Spaces
Claim Demonstration Identification Number	9(2)	980	981	Zeroes
PPS Indicator	X(1)	982	982	Spaces
Action Code	X(1)	983	983	Spaces
Patient Status	X(2)	984	985	Spaces
Billing Provider NPI	X(10)	986	995	Spaces
Claim Provider Taxonomy Code	X(25)	996	1020	Spaces
Medical Record Number	X(17)	1021	1037	Spaces
Patient Control Number	X(20)	1038	1057	Spaces

Field Name	Picture	From	Thru	Initialization
Attending Physician NPI	X(10)	1058	1067	Spaces
Attending Physician Last Name	X(16)	1068	1083	Spaces
Operating Physician NPI	X(10)	1084	1093	Spaces
Operating Physician Last Name	X(16)	1094	1109	Spaces
Claim Rendering Physician NPI	X(10)	1110	1119	Spaces
Claim Rendering Physician Last Name	X(16)	1120	1135	Spaces
Date of Admission	X(8)	1136	1143	Spaces
Type of Admission	X(1)	1144	1144	Spaces
Source of Admission	X(1)	1145	1145	Spaces
DRG	X(3)	1146	1148	Spaces
Occurrence Code 1	X(2)	1149	1150	Spaces
Occurrence Code 1 Date	X(8)	1151	1158	Spaces
Occurrence Code 2	X(2)	1159	1160	Spaces
Occurrence Code 2 Date	X(8)	1161	1168	Spaces
Occurrence Code 3	X(2)	1169	1170	Spaces
Occurrence Code 3 Date	X(8)	1171	1178	Spaces
Occurrence Code 4	X(2)	1179	1180	Spaces
Occurrence Code 4 Date	X(8)	1181	1188	Spaces
Occurrence Code 5	X(2)	1189	1190	Spaces
Occurrence Code 5 Date	X(8)	1191	1198	Spaces
Occurrence Code 6	X(2)	1199	1200	Spaces
Occurrence Code 6 Date	X(8)	1201	1208	Spaces
Occurrence Code 7	X(2)	1209	1210	Spaces
Occurrence Code 7 Date	X(8)	1211	1218	Spaces
Occurrence Code 8	X(2)	1219	1220	Spaces
Occurrence Code 8 Date	X(8)	1221	1228	Spaces
Occurrence Code 9	X(2)	1231	1230	Spaces
Occurrence Code 9 Date	X(8)	1231	1238	Spaces
Occurrence Code 10	X(2)	1239	1240	Spaces
Occurrence Code 10 Date	X(8)	1241	1248	Spaces
Occurrence Code 11	X(2)	1249	1250	Spaces
Occurrence Code 11 Date	X(8)	1251	1258	Spaces
Occurrence Code 12	X(2)	1259	1260	Spaces
Occurrence Code 12 Date	X(8)	1261	1268	Spaces
Occurrence Code 13	X(2)	1269	1270	Spaces
Occurrence Code 13 Date	X(8)	1271	1278	Spaces
Occurrence Code 14	X(2)	1279	1280	Spaces
Occurrence Code 14 Date	X(8)	1281	1288	Spaces
Occurrence Code 15	X(2)	1289	1290	Spaces
Occurrence Code 15 Date	X(8)	1291	1298	Spaces
Occurrence Code 16	X(2)	1299	1300	Spaces
Occurrence Code 16 Date	X(8)	1301	1308	Spaces
Occurrence Code 17	X(2)	1309	1310	Spaces
Occurrence Code 17 Date	X(8)	1311	1318	Spaces
Occurrence Code 18	X(2)	1319	1320	Spaces
Occurrence Code 18 Date	X(8)	1321	1328	Spaces

Field Name	Picture	From	Thru	Initialization
Occurrence Code 19	X(2)	1329	1330	Spaces
Occurrence Code 19 Date	X(8)	1331	1338	Spaces
Occurrence Code 20	X(2)	1339	1340	Spaces
Occurrence Code 20 Date	X(8)	1341	1348	Spaces
Occurrence Code 21	X(2)	1349	1350	Spaces
Occurrence Code 21 Date	X(8)	1351	1358	Spaces
Occurrence Code 22	X(2)	1359	1360	Spaces
Occurrence Code 22 Date	X(8)	1361	1368	Spaces
Occurrence Code 23	X(2)	1369	1370	Spaces
Occurrence Code 23 Date	X(8)	1371	1378	Spaces
Occurrence Code 24	X(2)	1379	1380	Spaces
Occurrence Code 24 Date	X(8)	1381	1388	Spaces
Occurrence Code 25	X(2)	1389	1390	Spaces
Occurrence Code 25 Date	X(8)	1391	1398	Spaces
Occurrence Code 26	X(2)	1399	1400	Spaces
Occurrence Code 26 Date	X(8)	1401	1408	Spaces
Occurrence Code 27	X(2)	1409	1410	Spaces
Occurrence Code 27 Date	X(8)	1411	1418	Spaces
Occurrence Code 28	X(2)	1419	1420	Spaces
Occurrence Code 28 Date	X(8)	1421	1428	Spaces
Occurrence Code 29	X(2)	1429	1430	Spaces
Occurrence Code 29 Date	X(8)	1431	1438	Spaces
Occurrence Code 30	X(2)	1439	1440	Spaces
Occurrence Code 30 Date	X(8)	1441	1448	Spaces
Value Code 1	X(2)	1449	1450	Spaces
Value Amount 1	S9(8)V99	1451	1460	Zeroes
Value Code 2	X(2)	1461	1462	Spaces
Value Amount 2	S9(8)V99	1463	1472	Zeroes
Value Code 3	X(2)	1473	1474	Spaces
Value Amount 3	S9(8)V99	1475	1484	Zeroes
Value Code 4	X(2)	1485	1486	Spaces
Value Amount 4	S9(8)V99	1487	1496	Zeroes
Value Code 5	X(2)	1497	1498	Spaces
Value Amount 5	S9(8)V99	1499	1508	Zeroes
Value Code 6	X(2)	1509	1510	Spaces
Value Amount 6	S9(8)V99	1511	1520	Zeroes
Value Code 7	X(2)	1521	1522	Spaces
Value Amount 7	S9(8)V99	1523	1532	Zeroes
Value Code 8	X(2)	1533	1534	Spaces
Value Amount 8	S9(8)V99	1535	1544	Zeroes
Value Code 9	X(2)	1545	1546	Spaces
Value Amount 9	S9(8)V99	1547	1556	Zeroes
Value Code 10	X(2)	1557	1558	Spaces
Value Amount 10	S9(8)V99	1559	1568	Zeroes
Value Code 11	X(2)	1569	1570	Spaces
Value Amount 11	S9(8)V99	1571	1580	Zeroes
Value Code 12	X(2)	1581	1582	Spaces
Value Amount 12	S9(8)V99	1583	1592	Zeroes

Field Name	Picture	From	Thru	Initialization
Value Code 13	X(2)	1593	1594	Spaces
Value Amount 13	S9(8)V99	1595	1604	Zeroes
Value Code 14	X(2)	1605	1606	Spaces
Value Amount 14	S9(8)V99	1607	1616	Zeroes
Value Code 15	X(2)	1617	1618	Spaces
Value Amount 15	S9(8)V99	1619	1628	Zeroes
Value Code 16	X(2)	1629	1630	Spaces
Value Amount 16	S9(8)V99	1631	1640	Zeroes
Value Code 17	X(2)	1641	1642	Spaces
Value Amount 17	S9(8)V99	1643	1652	Zeroes
Value Code 18	X(2)	1653	1654	Spaces
Value Amount 18	S9(8)V99	1655	1664	Zeroes
Value Code 19	X(2)	1665	1666	Spaces
Value Amount 19	S9(8)V99	1667	1676	Zeroes
Value Code 20	X(2)	1677	1678	Spaces
Value Amount 20	S9(8)V99	1679	1688	Zeroes
Value Code 21	X(2)	1689	1690	Spaces
Value Amount 21	S9(8)V99	1691	1700	Zeroes
Value Code 22	X(2)	1701	1702	Spaces
Value Amount 22	S9(8)V99	1703	1712	Zeroes
Value Code 23	X(2)	1713	1714	Spaces
Value Amount 23	S9(8)V99	1715	1724	Zeroes
Value Code 24	X(2)	1725	1726	Spaces
Value Amount 24	S9(8)V99	1727	1736	Zeroes
Value Code 25	X(2)	1737	1738	Spaces
Value Amount 25	S9(8)V99	1739	1748	Zeroes
Value Code 26	X(2)	1749	1750	Spaces
Value Amount 26	S9(8)V99	1751	1760	Zeroes
Value Code 27	X(2)	1761	1762	Spaces
Value Amount 27	S9(8)V99	1763	1772	Zeroes
Value Code 28	X(2)	1773	1774	Spaces
Value Amount 28	S9(8)V99	1775	1784	Zeroes
Value Code 29	X(2)	1785	1786	Spaces
Value Amount 29	S9(8)V99	1787	1796	Zeroes
Value Code 30	X(2)	1797	1798	Spaces
Value Amount 30	S9(8)V99	1799	1808	Zeroes
Value Code 31	X(2)	1809	1810	Spaces
Value Amount 31	S9(8)V99	1811	1820	Zeroes
Value Code 32	X(2)	1821	1822	Spaces
Value Amount 32	S9(8)V99	1823	1832	Zeroes
Value Code 33	X(2)	1833	1834	Spaces
Value Amount 33	S9(8)V99	1835	1844	Zeroes
Value Code 34	X(2)	1845	1846	Spaces
Value Amount 34	S9(8)V99	1847	1856	Zeroes
Value Code 35	X(2)	1857	1858	Spaces
Value Amount 35	S9(8)V99	1859	1868	Zeroes
Claim Final Allowed Amount	S9(8)V99	1869	1878	Zeroes
Claim Deductible Amount	S9(8)V99	1879	1888	Zeroes

Field Name	Picture	From	Thru	Initialization
Claim State	X(2)	1889	1890	Spaces
Claim Zip Code	X(9)	1891	1899	Spaces
Beneficiary State	X(2)	1900	1901	Spaces
Beneficiary Zip Code	X(9)	1902	1910	Spaces
Claim PWK	X(60)	1911	1970	Spaces
Patient Reason for Visit 1	X(7)	1971	1977	Spaces
Patient Reason for Visit 2	X(7)	1978	1984	Spaces
Patient Reason for Visit 3	X(7)	1985	1991	Spaces
Patient Reason for Visit 1 Version Indicator Code	X(1)	1992	1992	Spaces
Patient Reason for Visit 2 Version Indicator Code	X(1)	1993	1993	Spaces
Patient Reason for Visit 3 Version Indicator Code	X(1)	1994	1994	Spaces
Present on Admission/External Cause of Injury Indicator	X(37)	1995	2031	Spaces
External Cause of Injury 1	X(7)	2032	2038	Spaces
External Cause of Injury 2	X(7)	2039	2045	Spaces
External Cause of Injury 3	X(7)	2046	2052	Spaces
External Cause of Injury 4	X(7)	2053	2059	Spaces
External Cause of Injury 5	X(7)	2060	2066	Spaces
External Cause of Injury 6	X(7)	2067	2073	Spaces
External Cause of Injury 7	X(7)	2074	2080	Spaces
External Cause of Injury 8	X(7)	2081	2087	Spaces
External Cause of Injury 9	X(7)	2088	2094	Spaces
External Cause of Injury 10	X(7)	2095	2101	Spaces
External Cause of Injury 11	X(7)	2102	2108	Spaces
External Cause of Injury 12	X(7)	2109	2115	Spaces
External Cause of Injury 1 Version Indicator Code	X(1)	2116	2116	Spaces
External Cause of Injury 2 Version Indicator Code	X(1)	2117	2117	Spaces
External Cause of Injury 3 Version Indicator Code	X(1)	2118	2118	Spaces
External Cause of Injury 4 Version Indicator Code	X(1)	2119	2119	Spaces
External Cause of Injury 5 Version Indicator Code	X(1)	2120	2120	Spaces
External Cause of Injury 6 Version Indicator Code	X(1)	2121	2121	Spaces
External Cause of Injury 7 Version Indicator Code	X(1)	2122	2122	Spaces
External Cause of Injury 8 Version Indicator Code	X(1)	2123	2123	Spaces
External Cause of Injury 9 Version Indicator Code	X(1)	2124	2124	Spaces
External Cause of Injury 10 Version Indicator Code	X(1)	2125	2125	Spaces

Field Name	Picture	From	Thru	Initialization
External Cause of Injury 11 Version Indicator Code	X(1)	2126	2126	Spaces
External Cause of Injury 12 Version Indicator Code	X(1)	2127	2127	Spaces
Service Facility Zip Code	X(9)	2128	2136	Spaces
RAC adjustment indicator	X(1)	2137	2137	Spaces
Split/Adjustment Indicator	9(2)	2138	2139	Spaces
Referring Physician NPI	X(10)	2140	2149	Spaces
Referring Physician Last Name	X(16)	2150	2165	Spaces
Referring Physician Specialty	X(2)	2166	2167	Spaces
Claim Rendering Physician	X(2)	2168	2169	Spaces
Overpay Indicator	X(1)	2170	2170	Spaces
Overpay Code	X(3)	2171	2173	Spaces
Claim Demonstration Identification Number 2	X(2)	2174	2175	Spaces
Claim Demonstration Identification Number 3	X(2)	2176	2177	Spaces
Claim Demonstration Identification Number 4	X(2)	2178	2179	Spaces
Beneficiary MBI	X(11)	2180	2190	Spaces
MBI/HICN Indicator	X(1)	2191	2191	Spaces
Filler	X(10)	2192	2201	Spaces
Total Line Item Count	9(3)	2202	2204	Zeroes
Record Line Item Count	9(3)	2205	2207	Zeroes

Sampled Claims Resolution File
Sampled Claims Resolution Claim Line Item Group Record
*The following group of fields occurs from 1 to 450 times for the claim (depending on Total Line Item Count) and 1 to 75 times for the Record (depending on Record Line Item Count)

*From and Thru values relate to the 1st line item

Field Name	Picture	From	Thru	Initialization
Revenue center code	X(4)	2208	2211	Spaces
SNF-RUG-III code	X(3)	2212	2214	Spaces
APC adjustment code	X(5)	2215	2219	Spaces
HCPCS Procedure Code	X(5)	2220	2224	Spaces
HCPCS Modifier 1	X(2)	2225	2226	Spaces
HCPCS Modifier 2	X(2)	2227	2228	Spaces
HCPCS Modifier 3	X(2)	2229	2230	Spaces
HCPCS Modifier 4	X(2)	2231	2232	Spaces
HCPCS Modifier 5	X(2)	2233	2234	Spaces
Line Item Date	X(8)	2235	2242	Spaces
Line Submitted Charge	S9(8)V99	2243	2252	Zeroes
Line Medicare Initial Allowed	S9(8)V99	2253	2262	Zeroes
ANSI Reason Code 1	X(8)	2263	2270	Spaces
ANSI Reason Code 2	X(8)	2271	2278	Spaces
ANSI Reason Code 3	X(8)	2279	2286	Spaces

Field Name	Picture	From	Thru	Initialization
ANSI Reason Code 4	X(8)	2287	2294	Spaces
ANSI Reason Code 5	X(8)	2295	2302	Spaces
ANSI Reason Code 6	X(8)	2303	2310	Spaces
ANSI Reason Code 7	X(8)	2311	2318	Spaces
ANSI Reason Code 8	X(8)	2319	2326	Spaces
ANSI Reason Code 9	X(8)	2327	2334	Spaces
ANSI Reason Code 10	X(8)	2335	2342	Spaces
ANSI Reason Code 11	X(8)	2343	2350	Spaces
ANSI Reason Code 12	X(8)	2351	2358	Spaces
ANSI Reason Code 13	X(8)	2359	2366	Spaces
ANSI Reason Code 14	X(8)	2367	2374	Spaces
Manual Medical Review Indicator	X(1)	2375	2375	Spaces
Resolution Code	X(5)	2376	2380	Spaces

Field Name	Picture	From	Thru	Initialization
Line Final Allowed Charge	S9(8)V99	2381	2390	Zeroes
Line Cash Deductible	S9(8)V99	2391	2400	Zeroes
Special Action Code/Override Code	X(1)	2401	2401	Zeroes
Units	S9(7)v999	2402	2411	Zeroes
Rendering Physician NPI	X(10)	2412	2421	Spaces
Rendering Physician Last Name	X(25)	2422	2446	Spaces
National Drug Code (NDC) field	X(11)	2447	2457	Spaces
National Drug Code (NDC)	S9(7)v999	2458	2467	Spaces
National Drug Code (NDC) Quantity Qualifier	X(2)	2468	2469	Spaces
Line PWK	X(60)	2470	2529	Spaces
Line Rendering Physician specialty	X(2)	2530	2531	Spaces
Prior Authorization Program	X(4)	2532	2535	Spaces
Unique Tracking Number (UTN)	X(14)	2536	2549	Spaces
Prior Authorization Affirmed	X(1)	2550	2550	Spaces
Filler	X(4)	2551	2554	Spaces

DATA ELEMENT DETAIL

Claim (Header) Fields

Data Element: Contractor ID
Definition: Contractor's CMS assigned number.
Validation: Must be a valid CMS contractor ID.
Remarks: N/A
Requirement: Required
NOTE: For A/B MAC (A) and A/B MAC (HHH), when multiple workloads share asingle processing environment, the Contractor ID will reflect the roll-up Contractor ID specified by CMS.

Data Element: Record Type
Definition: Code indicating type of record
Validation: N/A

Remarks: 2 = Claim record
Requirement: Required

Data Element: Record Version Code
Definition: The code indicating the record version of the Claim Resolution file
Validation: Claim Resolution files prior to 10/1/2007 did not contain this field.
Codes:
B = Record Format as of 10/1/2007
C = Record Format as of 1/1/2010
D = Record Format as of 10/1/2012
E = Record Format as of 7/1/2016
F = Record Format as of 10/1/2017
Remarks: N/A
Requirement: Required

Data Element: Contractor Type

Definition: Type of Medicare Contractor included in the file
Validation: Must be 'A' or 'R'
Where the TYPE of BILL, 1st position = 3, Contractor Type should be 'R'.
Where the TYPE of BILL, 1st/2nd positions = 81 or 82, contractor Type should be 'R'.
All others will be contractor type 'A'.

Data Element: Record Number
Definition: The sequence number of the record. A claim may have up to six records.
Validation: Must be between 1 and 6
Remarks: None Requirement: Required

Data Element: Mode of Entry Indicator
Definition: Code that indicates if the claim is paper, EMC, or unknown
Validation: Must be 'E', 'P', or 'U'
Remarks: E = EMC
P = Paper
U= Unknown
Use the same criteria to determine EMC, paper, or unknown as that used for workload reporting
Requirement: Required

Data Element: Original Claim Control Number
Definition: The Claim Control Number the shared system assigned to the claim in the Universe file. This number should be the same as the claim control number for the claim in the Sample Claims Transactions file, and the claim control number for the claim on the Universe file. If the shared system had to use a crosswalk to pull the claim because the MAC or shared system changed the claim control number during processing, enter the number the shared system used to look up the number needed to pull all records associated with the sample claim.
Validation: For all records in the resolution file, the Original Claim Control must match the Claim Control Number identified in the Sampled Claims Transaction File.
Remarks: N/A
Requirement: Required

Data Element: Internal Control Number
Definition: Number currently assigned by the Shared System to uniquely identify the claim.
Validation: N/A
Remarks: Use the Original Claim Control Number if no adjustment has been made to the claim. This number may be different from the Original Claim Control Number if the shared system has assigned a new Claims Control Number to an adjustment to the claim requested.
Requirement: Required

Data Element: Beneficiary HICN
Definition: Beneficiary's Health Insurance Claim Number
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: Beneficiary Last Name
Definition: Last Name (Surname) of the beneficiary
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: Beneficiary First Name
Definition: First (Given) Name of the beneficiary
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: Beneficiary Middle Initial
Definition: First letter from Beneficiary Middle Name
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: Beneficiary Date of Birth
Definition: Birth date of the beneficiary
Validation: Must be a valid date
Remarks: MMDDCCYY on which the beneficiary was born
Requirement: Required

Data Element: Beneficiary Gender
Definition: Gender of the beneficiary
Validation: 'M' = Male, 'F' = Female, or 'U' = Unknown
Remarks: N/A
Requirement: Required

Data Element: Billing Provider Number
Definition: First nine characters of number used to identify the billing/pricing provider or supplier.
Validation: Must be present
If the same billing/pricing provider number does not apply to all lines on the claim, enter the Billing provider number that applies to the first line of the claim.

Remarks: N/A
Requirement: Required for all claims

Data Element: Attending Physician UPIN
Definition: The UPIN submitted on the claim used to identify the physician that is responsible for coordinating the care of the patient while in the facility.
Validation: N/A
Remarks: Left justify
Requirement: Required when available on claim record.

Data Element: Claim Paid Amount
Definition: Amount of payment made from the Medicare trust fund for the services covered by the claim record. Generally, the amount is calculated by the A/B MAC (A) or A/B MAC (B) and represents what CMS paid to the institutional provider, physician, or supplier, i.e. The Claim Paid Amount is the net amount paid after co-insurance and deductibles are applied.
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: Claim ANSI Reason Code 1-7
Definition: Codes showing the reason for any adjustments to this claim, such as denials or reductions of payment from the amount billed.
Validation: Must be valid American National Standards Institute (ANSI) Ambulatory Surgical Center (ASC) claim adjustment code and applicable group code.
Remarks: Format is GGRRRRRR where: GG is the group code and RRRRRR is the adjustment reason code.
Requirement: Report all ANSI reason codes on the bill

Data Element: Statement Covers from Date
Definition: The beginning date of the statement
Validation: Must be a valid date
Remarks: Format must be CCYYMMDD
Requirement: Required

Data Element: Statement Covers thru Date
Definition: The ending date of the statement
Validation: Must be a valid date
Remarks: Format must be CCYYMMDD
Requirement: Required

Data Element: Claim Entry Date
Definition: Date claim entered the shared claim processing system, the receipt date
Validation: Must be a valid date
Remarks: Format must be CCYYMMDD
Requirement: Required

Data Element: Claim Adjudicated Date
Definition: Date claim completed adjudication, i.e., process date
Validation: Must be a valid date
Remarks: Format must be CCYYMMDD Requirement: Required

Data Element: Condition Code 1 -30
Definition: The code that indicates a condition relating to an institutional claim that may affect payer processing
Validation: Must be a valid code as listed in Pub 100-4, Medicare Claims Processing Manual, Chapter 25, Completing and Processing CMS-1450 Data Set.
Remarks: This field is left justified and blank filled.
Requirement: Required if there is a condition code for the bill.
Data Element: Type of Bill
Definition: A code indicating the specific type of bill (hospital, inpatient, SNF, outpatient, adjustments, voids, etc.). This three-digit alphanumeric code gives three specific pieces of information. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this bill in this particular episode of care. It is referred to as "frequency" code.
Validation: Must be a valid code as listed in Pub 100-4, Medicare Claims Processing Manual, Chapter 25, Completing and Processing CMS-1450 Data Set
Remarks: N/A
Requirement: Required

Data Element: Principal Diagnosis
Definition: The current version of ICD--CM diagnosis code identifying the diagnosis, condition, problem or other reason for the admission/encounter/visit shown in the medical record to be chiefly responsible for the services provided.
Validation: Must be a valid ICD--CM diagnosis code

- CMS accepts only CMS approved ICD--CM diagnostic and procedural codes. The CMS approves only changes issued by the Federal ICD-- CM Coordination and Maintenance Committee.
- Diagnosis codes must be full ICD--CM diagnoses codes, including the full number of digits (five for ICD-9-CM, seven for ICD-10-CM) where applicable.

Remarks: The principal diagnosis is the condition established after study to be chiefly responsible for this admission. Even though another diagnosis may be more severe than the principal diagnosis, the principal diagnosis, as defined above, is entered.
Requirement: Required

Data Element: Principal Diagnosis Version Indicator Code
Definition: The diagnosis version code identifying the version of ICD diagnosis code submitted.
Validation:

- Version ICD9 use Version Code '9'
- Version ICD10 use Version Code '0'

Remarks: With the exception of claims submitted by ambulance suppliers (specialty).
Requirement: Principal Diagnosis Version Code 1 is required for ALL claims.

Data Element: Other Diagnosis Code 1-24
Definition: The ICD-CM diagnosis code identifying the diagnosis, condition, problem or other reason for the admission/encounter/visit shown in the medical record to be present during treatment.
Validation: Must be a valid ICD--CM diagnosis code

- CMS accepts only CMS approved ICD-CM diagnostic and procedural codes. The CMS approves only changes issued by the Federal ICD-CM Coordination

and Maintenance Committee.

- Diagnosis codes must be full ICD-CM diagnoses codes, including The full number of digits (five for ICD-9-CM, seven for ICD-10-CM) where applicable.

Remarks: Report the full ICD-CM codes for up to 24 additional conditions if they co-existed at the time of admission or developed subsequently, and which had an effect upon the treatment or the length of stay.

Requirement: Required if available on the claim record.

Data Element: Other Diagnosis Version Indicator Code 1-24

Definition: The ICD-CM diagnosis version code identifying the version of diagnosis code submitted.

Validation:

- Version ICD9 use Version Code '9'
- Version ICD10 use Version Code '0

Remarks: N/A

Requirement: Principal Diagnosis Version Code 1 is required for ALL claims. Other Diagnosis version codes 1-24 should be submitted to correspond to claim level diagnosis codes 1-24.

Data Element: Principal Procedure and Date

Definition: The ICD--CM code that indicates the principal procedure performed during the period covered by the institutional claim. And the Date on which it was performed.

Validation: Must be a valid ICD--CM procedure code

- CMS accepts only CMS approved ICD--CM diagnostic and procedural codes. The CMS approves only changes issued by the Federal ICD--CM Coordination and Maintenance Committee.
- The procedure code shown must be the full ICD--CM, Volume 3, procedure code, including the full number of digits (five for ICD-9-CM, seven for ICD-10-CM).

Remarks: The principal procedure is the procedure performed for definitive treatment rather than for diagnostic or exploratory purposes, or which was necessary to take care of a complication. It is also the procedure most closely related to the principal diagnosis.

- The date applicable to the principal procedure is shown numerically as CCYYMMDD in the "date" portion.

Requirement: Required for inpatient claims.

Data Element: Principal Procedure Version Indicator Code

Definition: The version code identifying the version of ICD procedure code submitted.

Validation:

- Version ICD9 use Version Code '9'
- Version ICD10 use Version Code '0'

Remarks: N/A

Requirement: Principal Procedure Code Version Code is required for ALL claims containing a Principal Procedure.

Data Element: Other Procedure and Date 1-24

Definition: The ICD-CM code identifying the procedure, other than the principal procedure, performed during the billing period covered by this bill.

Validation: Must be a valid ICD-CM procedure code

- CMS accepts only CMS approved ICD-CM diagnostic and procedural codes. The CMS approves only changes issued by the Federal ICD-CM Coordination and Maintenance Committee.
- The procedure code shown must be the full ICD-CM, Volume 3, procedure code, including the full number of digits (five for ICD-9-CM, seven for ICD-10-CM).

Remarks: The date applicable to the procedure is shown numerically as CCYYMMDD in the "date" portion.

Requirement: Required if on claim record.

Data Element: Other Procedure Code Version Indicator Code 1-24

Definition: The ICD-CM diagnosis version code identifying the version of procedure code submitted

Validation:

- Version ICD9 use Version Code '9'
- Version ICD10 use Version Code '0'

Remarks: N/A

Requirement: Principal Procedure Version Code is required for ALL claims. Other Procedure version codes 1-24 should be submitted to correspond to other procedure code 1-24.

Data Element: Claim Demonstration Identification Number

Definition: The number assigned to identify a demonstration project.

Validation: Must be numeric or zeroes

Remarks: This field contains the value from the first populated demonstration field.

Requirement: Required for all claims involved in a demonstration project

Data Element: PPS Indicator

Definition: The code indicating whether (1) the claim is Prospective Payment System (PPS) or not PPS.

Validation: 0 = Not PPS
1 = PPS

Remarks: N/A

Requirement: Required

Data Element: Action Code

Definition: Indicator identifying the type of action requested by the intermediary to be taken on an institutional claim.

Validation: Must be a valid action code.

1 = Original debit action (includes non-adjustment RTI correction items) – it will always be a 1 in regular bills.
2 = Cancel by credit adjustment – used only in credit/debit pairs (under HHPPS, updates the RAP).
3 = Secondary debit adjustment - used only in credit/debit pairs (under HHPPS, would be the final claim or an adjustment on a LUPA).
4 = Cancel only adjustment (under HHPPS, RAP/final claim/LUPA).

5 = Force action code 3.
6 = Force action code 2.
8 = Benefits refused (for inpatient bills, an 'R' nonpayment code must also be present.
9 = Payment requested (used on bills that replace previously-submitted benefits-refused bills, action code 8. In such cases a debit/credit pair is not required. For inpatient bills, a 'P' should be entered in the nonpayment code.)

Remarks: N/A
Requirement: Required

Data Element: Patient Status
Definition: This code indicates the patient's status as of the "Through" date of the billing period.
Validation: Must be a valid code as listed in Pub 100-4, Medicare Claims Processing Manual, Chapter 25, Completing and Processing CMS-1450 Data Set.
Remarks: N/A
Requirement: Required

Data Element: Billing Provider NPI
Definition: NPI assigned to the Billing Provider.
Validation: N/A
Remarks: N/A.
Requirement: Required for providers using HIPAA standard transactions

Data Element: Claim Provider Taxonomy Code
Definition: The non-medical data code set used to classify health care providers according to provider type or practitioner specialty in an electronic environment, specifically within the American National Standards Institute Accredited Standards Committee health care transaction.
Validation: Must be present
- If multiple taxonomy codes are associated with a provider number, provide the first one in sequence.

Remarks: N/A
Requirement: Required when available.

Data Element: Medical Record Number
Definition: Number assigned to patient by hospital or other provider to assist in retrieval of medical records.
Validation: N/A
Remarks: N/A
Requirement: Required if available on claim record

Data Element: Patient Control Number
Definition: The patient's unique alpha-numeric control number assigned by the provider to facilitate retrieval of individual financial records and posting payment.
Validation: N/A
Remarks: N/A
Requirement: Required if available on claim record

Data Element: Attending Physician NPI
Definition: NPI assigned to the Attending Physician.
Validation: N/A

Remarks: Left justify
Requirement: Required when available on claim record.

Data Element: Attending Physician Last Name
Definition: Last Name (Surname) of the attending physician.
Validation: Must be present

Remarks: N/A
Requirement: Required when available on claim record

Data Element: Operating Physician NPI
Definition: NPI assigned to the Operating Physician.
Validation: N/A
Remarks: Left justify
Requirement: Required when available on claim record.

Data Element: Operating Physician Last Name
Definition: Last Name (Surname) of the operating physician.
Validation: Must be present
Remarks: N/A
Requirement: Required when available on claim record

Data Element: Claim Rendering Physician NPI
Definition: NPI assigned to the claim rendering physician (mapped from 2310D from the 837I version 5010A2).
Validation: N/A
Remarks: Left justify
Requirement: Required when available on claim record.

Data Element: Claim Rendering Physician Last Name
Definition: Last Name (Surname) of the claim rendering physician (mapped from 2310D from the 837I version 5010A2).
Validation: Must be present
Remarks: N/A
Requirement: Required when available on claim record

Data Element: Date of Admission
Definition: The date the patient was admitted to the provider for inpatient care, outpatient service, or start of care. For an admission notice for hospice care, enter the effective date of election of hospice benefits.
Validation: Must be a valid date
Remarks: Format date as CCYYDDD
Requirement: Required if on claim record.

Data Element: Type of Admission
Definition: The code indicating the type and priority of an inpatient admission associated with the service on an intermediary claim.
Validation: Must be a valid code as listed in Pub 100-4, Medicare Claims Processing Manual, Chapter 25, Completing and Processing CMS-1450 Data Set Code Structure.
Remarks: N/A
Requirement: Required on inpatient claims only.

Data Element: Source of Admission
Definition: The code indicating the means by which the beneficiary was admitted to the inpatient health care facility or SNF if the type of admission is (1) emergency, (2) urgent, or (3) elective.
Validation: Must be a valid code as listed in Pub 100-4, Medicare Claims Processing Manual, Chapter 25, Completing and Processing CMS-1450 Data Set Code Structure (For Emergency, Elective, or Other Type of Admission)
Remarks: N/A
Requirement: Required when entered on the claim record.

Data Element: DRG (Diagnosis Related Group)
Definition: The code identifying the diagnostic related group to which a hospital claim belongs for prospective payment purposes.
Validation: Must be valid per the DRG DEFINITIONS MANUAL
Remarks: N/A
Requirement: Required if available on the claim record

Data Element: Occurrence Code and Date 1-30
Definition: Code(s) and associated date(s) defining specific event(s) relating to this billing period are shown.
Validation: Must be a valid code as listed in Pub 100-4, Medicare Claims Processing Manual, Chapter 25, Completing and Processing CMS-1450 Data Set.
Remarks:

- Event codes are two alpha-numeric digits, and dates are shown as eight numeric digits (MM-DD-CCYY)
- When occurrence codes 01-04 and 24 are entered, make sure the entry includes the appropriate value codes, if there is another payer involved.

Requirement: Required if available on claim record

Data Element: Value Codes and Amounts 1-35
Definition: Code(s) and related dollar or unit amount(s) identify data of a monetary nature that are necessary for the processing of this claim.
Validation: Must be a valid code as listed in Pub 100-4, Medicare Claims Processing Manual, Chapter 25, Completing and Processing CMS-1450 Data Set.
Remarks:

- The codes are two alpha-numeric digits, and each value allows up to nine numeric digits (0000000.00).
- Negative amounts are not allowed except in the last entry.
- Whole numbers or non-dollar amounts are right justified to the left of the dollars and cents delimiter.
- Some values are reported as cents, so refer to specific codes for instructions.
- If more than one value code is shown for a billing period, codes are shown in ascending numeric sequence.
- Use the first line before the second, etc.

Requirement: Required if available on claim record

Data Element: Claim Final Allowed Amount
Definition: Final Allowed Amount for this claim.
Validation: N/A

Remarks: The Gross Allowed charges on the claim. This represents the amount paid to the provider plus any beneficiary responsibility (co-pay and deductible)
Requirement: Required

Data Element: Claim Deductible Amount
Definition: Amount of deductible applicable to the claim.
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: Claim State
Definition: 2 character indicator showing the state where the service is furnished.
Validation: Must be a valid USPS state abbreviation
Remarks: N/A
Requirement: Required

Data Element: Claim Zip Code
Definition: Zip code of the physical location where the services were furnished.
Validation: Must be a valid USPS zip code.
Remarks: N/A
Requirement: Required

Data Element: Beneficiary State
Definition: 2 character indicator showing the state of beneficiary residence.
Validation: Must be a valid USPS state abbreviation
Remarks: N/A
Requirement: Required

Data Element: Beneficiary Zip Code
Definition: Zip code associated with the beneficiary residence.
Validation: Must be a valid USPS zip code.
Remarks: N/A
Requirement: Required

Data Element: PWK Filler
Definition: PWK space -- use to be determined
Validation: N/A
Remarks: N/A
Requirement: Required when available on claim.

Data Element: Patient Reason for Visit 1-3
Definition: An ICD--CM code on the institutional claim indicating the beneficiary's reason for visit.
Validation: Must be a valid ICD-CM diagnosis code.

- CMS accepts only CMS approved ICD-CM diagnostic and procedural codes. The CMS approves only changes issued by the Federal ICD-CM Coordination and Maintenance Committee.
- Diagnosis codes must be full ICD-CM diagnoses codes, including the full number of digits (five for ICD-9-CM, seven for ICD-10- CM) where applicable.

Remarks: Report the full ICD-CM codes for up to 3 conditions responsible for the patient's visit.

Requirement: For OP claims, this field is populated for those claims that are required to process through OP PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field. Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services.

Data Element: Patient Reason for Visit Version Indicator Code 1-3
Definition: The ICD-CM diagnosis version code identifying the version of diagnosis code submitted.
Validation:

- Version ICD9 use Version Code '9'
- Version ICD10 use Version Code '0'

Remarks: N/A
Requirement: Patient Reason for Visit Version codes must be submitted to correspond to patient reason for visit codes 1-3.

Data Element: Present on Admission/External Cause of Injury Indicator
Definition: The code used to indicate a condition was present at the time the beneficiary was admitted to a general acute care facility.
Validation: Position 1 for Principle Diagnosis, positions 2-25 for the 24 Secondary Diagnosis for the Present on Admission (POA) Indicator, Positions 26 – 37 for the 12 External Cause of Injury.
Remarks: N/A
Requirement: Required

Data Element: External Cause of Injury Diagnosis Codes 1-12
Definition: The ICD-CM code used to identify the external cause of injury, poisoning, or other adverse effect.
Validation: Must be a valid ICD--CM diagnosis code.

- CMS accepts only CMS approved ICD-CM diagnostic and procedural codes. The CMS approves only changes issued by the Federal ICD-CM Coordination and Maintenance Committee.
- Diagnosis codes must be full ICD-CM diagnoses codes, including the full number of digits (five for ICD-9-CM, seven for ICD-10- CM) where applicable.

Remarks: Report the full ICD-CM codes for up to 12 conditions resulting from external causes.
Requirement: Required if available on the claim record.

Data Element: External Cause of Injury Version Indicator Code 1-12
Definition: The ICD-CM diagnosis version code identifying the version of diagnosis code identified as external cause of injury.

Validation:

- Version ICD9 use Version Code '9'
- Version ICD10 use Version Code '0

Remarks: N/A
Requirement: External Cause of Injury version codes 1-12 should be submitted to correspond to external cause of injury diagnosis codes 1-12.

Data Element: Service Facility Zip Code
Definition: Zip Code used to identify were the service was furnished.
Validation: Must be a valid Zip Code
Remarks: N/A
Requirement: Required, if available on claim record.

Data Element: RAC Adjustment Indicator
Definition: Indicator used to identify RAC requested adjustments, which occur as a result of post-payment review activities done by the Recovery Audit Contractors (RAC).
Validation: 'R' identifies a RAC-requested adjustment
Remarks: N/A
Requirement: Required when RAC adjustment indicator was furnished to CWF.

Data Element: Split/Adjustment Indicator
Definition: Count of number of adjustments (with different DCNs) of the claim that are included in the resolution file.
Validation: '0' is used when only one DCN associated with the sampled claim is included in the resolution file.

When the resolution file contains multiple adjustments associated with a single claim, this field will provide a count of records.

- When the resolution file contains 2 DCNs related to a single claim, one of the records would contain a split/adjustment indicator of 1 and the second record would contain a split/adjustment indicator of 2.

Remarks: This indicator does not apply when multiple records are submitted for a single claim record because of size restrictions.

CERT recognizes that Part A claims are not split. For Part A this field will identify adjustments only.
Requirement: Required when the resolution file contains multiple versions of a single claim.

Data Element: Referring Physician NPI
Definition: NPI assigned to the Referring Physician—the physician who requests an item or service for the beneficiary for which payment may be made under the Medicare program.
Validation: N/A
Remarks: Enter zeros if there is no referring physician
Requirement: Required when available on the claim record
NOTES:

- Referring physician - is a physician who requests an item or service for the beneficiary for which payment may be made under the Medicare program.
- Ordering physician - is a physician or, when appropriate, a non- physician practitioner who orders non-physician services for the patient.

Data Element: Referring Physician Last Name
Definition: Last name of the referring physician.
Validation: N/A
Remarks: Enter zeros if there is no referring/ordering provider
Requirement: Required when available on the claim record.

Data Element: Referring Physician Specialty
Definition: Code indicating the primary specialty of the referring physician.
Validation: N/A
Remarks: Enter zeros if the referring physician specialty is not available
Requirement: Required when available on the claim record.

Data Element: Claim Rendering Physician Specialty
Definition: Code indicating the primary specialty of the claim rendering physician.
Validation: N/A
Remarks: Enter zeros if the rendering physician specialty is not available
Requirement: Required when available on the claim record.

Data Element: Overpay Indicator
Definition: Code indicating whether or not an overpayment exists on an OIG or *UPIC* tracked adjustment claims.

Validation:

- Y indicates an overpayment exists on an OIG or *UPIC* claim
- N indicates an overpayment does not exist on an OIG or *UPIC* claim.
- Default value is blank for claims that are not OIG or *UPIC* tracked claims.

Remarks: This field is populated only when there is a value present in the FSSCIDRP-OVERPAY-CODE field
Requirement: Required when available on the claim record.

Data Element: Overpay Code
Definition: Code that identifies an overpayment on an OIG or *UPIC* tracked adjustment claim.
Validation: Any of the user-defined values present in the online parm PRMOIGAA, PRMOIG00 through PRMOIG20 records.
Remarks: This field is populated only when the claim is an OIG or *UPIC* tracked adjustment claim.
Requirement: Required when available on the claim record.

Data Element: Claim Demonstration Identification Number 2
Definition: The number assigned to identify a demonstration project.
Validation: Must be numeric or zeroes
Remarks: This field contains the value from the second populated demonstration field.
Requirement: Required when available on the claim

Data Element: Claim Demonstration Identification Number 3
Definition: The number assigned to identify a demonstration project.
Validation: Must be numeric or zeroes
Remarks: This field contains the value from the third populated demonstration field.

Requirement: Required when available on the claim

Data Element: Claim Demonstration Identification Number 4
Definition: The number assigned to identify a demonstration project.
Validation: Must be numeric or zeroes.
Remarks: This field contains the value from the fourth populated demonstration field.
Requirement: Required when available on the claim.

Data Element: Beneficiary MBI
Definition: Beneficiary's Medicare Beneficiary Identifier
Validation: Comply with CMS Standards

- 11-character, fixed length alpha-numeric string
- Different, visibly distinguishable from HICN/RRB numbers
- Contain no more than 2 consecutive numbers
- Contain no more than 2 consecutive alphabetic characters
- Must limit the possibility of letters being interpreted as numbers (i.e., alphabetic characters [A…Z]; excluding S, L, O, I, B, Z)
- Must not contain lowercase letters
- Must not contain any special characters

Remarks: Do not include hyphens or spaces
Requirement: Required

Data Element: HICN/MBI Indicator
Definition: Indicator that identifies if the provider submitted the claim with a HICN or MBI
Validation:
M = MBI submitted on the claim
H = HICN submitted on the claim
Remarks: N/A
Requirement: Required

Data Element: Filler
Definition: Additional space -- use to be determined
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: Total Line Item Count
Definition: Number indicating number of service lines on the claim
Validation: Must be a number 001 - 450
Remarks: N/A
Requirement: Required

Data Element: Record Line Item Count
Definition: Number indicating number of service lines on this record
Validation: Must be a number 001 - 100
Remarks: N/A
Requirement: Required

<u>Claim Line Item Fields</u>

Data Element: Revenue Center Code

Definition: Code assigned to each cost center for which a charge is billed.
Validation: Must be a valid NUBC-approved code.
Must be a valid code as listed in Pub 100-4, Medicare Claims Processing Manual, Chapter 25, Completing and Processing CMS-1450 Data Set.
Remarks: Include an entry for revenue code '0001'
Requirement: Required

Data Element: NF-RUG-III Code
Definition: Skilled Nursing Facility Resource Utilization Group Version III (RUG-III) descriptor. This is the rate code/assessment type that identifies (1) RUG-III group the beneficiary was classified into as of the Minimum Data Set (MDS) assessment reference date and (2) the type of assessment for payment purposes.
Validation: N/A
Remarks: N/A
Requirement: Required for SNF inpatient bills

Data Element: APC Adjustment Code
Definition: The Ambulatory Payment Classification (APC) Code or Home Health Prospective Payment System (HIPPS) code. The APC codes are the basis for the calculation of payment of services made for hospital outpatient services, certain PTB services furnished to inpatients who have no Part A coverage, CMHCs, and limited services provided by CORFs, Home Health Agencies or to hospice patients for the treatment of a non-terminal illness.

This field may contain a HIPPS code. If a HHPPS HIPPS code is down coded, the down coded HIPPS will be reported in this field.

The HIPPS code identifies (1) the three case-mix dimensions of the Home Health Resource Group (HHRG) system, clinical, functional and utilization, from which a beneficiary is assigned to one of the 80 HHRG categories and (2) it identifies whether or not the elements of the code were computed or derived. The HHRGs, represented by the HIPPS coding, is the basis of payment for each episode.
Validation: N/A
Remarks: Left justify the APC Adjustment Code
Requirement: Required if present on claim record

Data Element: HCPCS Procedure Code or HIPPS Code
Definition: The HCPCS/CPT-4 code that describes the service or Health Insurance PPS (HIPPS) code.
Validation: Must be a valid HCPCS/CPT-4 or HIPPS code
Remarks: Healthcare Common Procedure Coding System (HCPCS) is a collection of codes that represent procedures, supplies, products and services which may be provided to Medicare beneficiaries and to individuals enrolled in private health insurance programs

When revenue center code = '0022' (SNF PPS), '0023' (HH PPS), or '0024' (IRF PPS); this field contains the Health Insurance PPS (HIPPS) code.

The HIPPS code for SNF PPS contains the rate code/assessment type that identifies RUG-III group the beneficiary was classified into as of the RAI MDS assessment reference date and (2) the type of assessment for payment purposes.

The HIPPS code for Home Health PPS identifies (1) the three case-mix dimensions of the HHRG system, clinical, functional and utilization, from which a beneficiary is assigned to one of the 80 HHRG categories and (2) it identifies whether or not the elements of the code were computed or derived. The HHRGs, represented by the HIPPS coding, will be the basis of payment for each episode.

The HIPPS code (CMG Code) for IRF PPS identifies the clinical characteristics of the beneficiary. The HIPPS rate/CMG code (AXXYY - DXXYY) must contain five digits. The first position of the code is an A, B, C, or 'D'. The HIPPS code beginning with an 'A' in front of the CMG is defined as without co-morbidity. The 'B' in front of the CMG is defined as with co-morbidity for Tier 1. The 'C' is defined as co-morbidity for Tier 2 and 'D' is defined as co-morbidity for Tier 3. The 'XX' in the HIPPS rate code is the Rehabilitation Impairment Code (RIC). The 'YY' is the sequential number system within the RIC.

Requirement: Required if present on claim record

Data Element: HCPCS Modifier 1
HCPCS Modifier 2
HCPCS Modifier 3
HCPCS Modifier 4
HCPCS Modifier 5
Definition: Codes identifying special circumstances related to the service
Validation: N/A
Remarks: N/A
Requirement: Required if available

Data Element: Line Item Date
Definition: The date the service was initiated
Validation: Must be a valid date.
Remarks: Format is CCYYMMDD
Requirement: Required if on bill and included in the shared system

Data Element: Line Submitted Charge
Definition: Actual charge submitted by the provider or supplier for the service or equipment
Validation: N/A
Remarks: This is a required field. CR3997 provided direction on how to populate this field if data is not available in the claim record.
Requirement: Required

Data Element: Line Medicare Initial Allowed Charge
Definition: Amount Medicare allowed for the service or equipment before any reduction or denial.
Validation: Must be a numeric value.
Remarks: This is a required field. Use the value in FISS field FSSCPDCL-REV-COV-CHRG- AMT to populate this field (per CMS Change Request 3912).
Requirement: Required

Data Element: ANSI Reason Code 1-14
Definition: Codes showing the reason for any adjustments to this line, such as denials or reductions of payment from the amount billed.
Validation: Must be valid ANSI ASC claim adjustment codes and applicable group codes.

Remarks: Format is GGRRRRRR where: G is the group code and RRRRRR is the adjustment reason code.
Requirement: Report all ANSI Reason Codes included on the bill.

Data Element: Manual Medical Review Indicator
Definition: Code indicating whether or not the service received complex manual medical review. Complex review goes beyond routine review. It includes the request for, collection of, and evaluation of medical records or any other documentation in addition to the documentation on the claim, attached to the claim, or contained in the MAC's history file. The review must require professional medical expertise and must be for the purpose of preventing payments of non-covered or incorrectly coded services. That includes reviews for the purpose of determining if services were medically necessary. Professionals must perform the review, i.e., at a minimum, a Licensed Practical Nurse must perform the review. Review requiring use of the MAC's history file does not make the review a complex review. A review is not considered complex if a medical record is requested from a provider and not received. If sufficient documentation accompanies a claim to allow complex review to be done without requesting additional documentation, count the review as complex. For instance if all relative pages from the patient's medical record are submitted with the claim, complex MR could be conducted without requesting additional documentation.
Validation: Must be 'Y' or 'N'
Remarks: Set to 'Y' if service was subjected to complex manual medical review, else 'N'.
Requirement: Required

Data Element: Resolution Code
Definition: Code indicating how the MAC resolved the line.

Automated Review (AM): An automated review occurs when a claim/line item passes through the MAC's claims processing system or any adjunct system containing medical review edits.

Routine Manual Review (MR): Routine review uses human intervention, but only to the extent that the claim reviewer reviews a claim or any attachment submitted by the provider. It includes review that involves review of any of the MAC's internal documentation, such as claims history file or policy documentation. It does not include review that involves review of medical records or other documentation requested from a provider. A review is considered routine if a medical record is requested from a provider and not received. Include prior authorization reviews in this category.

Complex Manual Review (MC): Complex review goes beyond routine review. It includes the request for, collection of, and evaluation of medical records or any other documentation in addition to the documentation on the claim, attached to the claim, or contained in the MAC's history file. The review must require professional medical expertise and must be for the purpose of preventing payments of non- covered or incorrectly coded services. Professionals must perform the review, i.e., at a minimum; a Licensed Practical Nurse must perform the review. Review requiring use of the MAC's history file does not make the review a complex review. A review is not considered complex if a medical record is requested from a provider and not received. If sufficient documentation accompanies a claim to allow complex review to be done without requesting

additional documentation, the review is complex. For instance if all relevant pages from the patient's medical record are submitted with the claim, complex MR could be conducted without requesting additional documentation.

Validation: Must be ‘APP’, ‘APPMR’, ’APPMC’, ’DENMR’, ‘DENMC’, ’DEO’,‘RTP’, ‘REDMR’, ‘REDMC’, ‘REO’, ‘DENAM’, ‘REDAM’,’INACT’.

Remarks:

Resolution Code	Description
APP	Approved as a valid submission without manual medical review.
APPAM	Approved after automated medical review
APPMR	Approved after manual medical review routine
APPMC	Approved after manual medical review complex. If this code is selected, set the Manual Medial Review Indicator to 'Y.
DENAM	Denied after automated medical review
DENMR	Denied for medical review reasons or for insufficient documentation of medical necessity, manual medical review routine
DENMC	Denied for medical review reasons or for insufficient documentation medical necessity, manual medical review complex. If this codes is selected, set the Manual Medial Review Indicator to 'Y.'
DEO	Denied for non-medical reasons, other than denied as unprocessable.
RTP	Denied as unprocessable (return/reject)
REDAM	Reduced after medical review
REDMR	Reduced for medical review reasons or for insufficient documentation of medical necessity, manual medical review routine
REDMC	Reduced for medical review reasons or for insufficient documentation of medical necessity, manual medical review complex. If this code is selected, set the Manual Medial Review Indicator to 'Y.'
REO	Reduced for non-medical review reasons.
INACT	Claim is inactive as identified by “I” Status

Requirement: Required

Data Element: Final Allowed Charge
Definition: Final amount paid to the provider for this service or equipment plus patient responsibility.
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: Cash Deductible
Definition: The amount of cash deductible the beneficiary paid for the line item service.
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: Special Action/Override Code
Definition: Code used to identify special actions taken in determining payment of this line item.
Validation: Must be valid
Remarks: N/A
Requirement: Required

Data Element: Units
Definition: The total number of services or time periods provided for the line item.
Validation: N/A
Remarks: Zero filled to maintain the relative position of the decimal point. The last three positions should contain the value to the right of the decimal in the number of services. Put a zero in the last three positions for whole numbers. For example if the number of units is 10, this field would be filled as 0000010000.
Requirement: Required

Data Element: Rendering Physician NPI
Definition: NPI assigned to the Rendering Physician.
Validation: N/A
Remarks: Left justify
Requirement: Required when available on claim record.

Data Element: Rendering Physician Last Name
Definition: Last Name (Surname) of the rendering physician.
Validation: Must be present
Remarks: N/A
Requirement: Required when available on claim record

Data Element: National Drug Code (NDC) field
Definition: To be assigned at a later date.
Validation: N/A
Remarks: Left justify
Requirement: Required when available on claim record.

Data Element: National Drug Code (NDC) Quantity Qualifier
Definition: To be assigned at a later date.
Validation: Must be present.
Remarks: N/A
Requirement: Required when available on claim record.

Data Element: National Drug Code (NDC) Quantity
Definition: To be assigned at a later date.
Validation: Must be present.
Remarks: Zero filled to maintain the relative position of the decimal point.

For example, if the number of units is 10, this field would be filled as 0000010000.

Requirement: Required when available on claim record.

Data Element: PWK Filler
Definition: PWK space -- use to be determined.
Validation: N/A
Remarks: N/A
Requirement: Required when available on claim

Data Element: Rendering Physician Specialty
Definition: Code indicating the primary specialty of the rendering physician.
Validation: N/A
Remarks: Enter zeros if the rendering physician specialty is not available
Requirement: Required when available on the claim record.

Data Element: Prior Authorization Program Indicator
Definition: Prior Authorization Program Indicator issued by CMS to identify to which PA program the service belongs
Validation:
- Four character alphanumeric
- The first character identifies the line of business
    - A for Part A,
    - B for Part B,
    - D for DME,
    - H for Home Health and Hospice
- Followed by a three digit number.

Remarks: N/A
Requirement: Required for claims containing services subject to a prior authorization program.

Data Element: Unique Tracking Number (UTN)
Definition: Unique Tracking Number (UTN) assigned to the prior authorization request for the service or item.
Validation: UTN shall be 14 characters and use the following format:
- First two characters = MAC identifier (e.g., RR for Railroad, 0F for Jurisdiction F, 05 for Jurisdiction 5, etc.).
- Third character = line of business (e.g., A for Part A, B for Part B, D for DME, H for Home Health and Hospice).
- Remaining numerical characters = a unique sequence number assigned by the Shared System.

Remarks: N/A
Requirement: Required for claims containing services covered by an affirmed prior authorization.

Data Element: Prior Auth Affirmed
Definition: Code to identify if the prior authorization for the service(s) on this line was affirmed.
Validation:
- Y indicates the prior authorization was affirmed.
- N indicates the prior authorization was not affirmed.
- Default value is blank for claims that are not part of prior authorization demonstration.

Remarks: N/A
Requirement: Required for claims containing services subject to prior authorization in the state where the service was furnished.

Data Element: Filler
Definition: Additional space -- use to be determined
Validation: N/A
Remarks: N/A
Requirement: Required

Claims Resolution File
Claims Resolution Trailer Record (one record per file)

Field Name	Picture	From	Thru	Initialization
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	'3'
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Number of Claims	9(9)	9	17	Zeroes

DATA ELEMENT DETAIL

Data Element: Contractor ID
Definition: Contractor's CMS assigned number.
Validation: Must be a valid CMS contractor ID.
Remarks: N/A
Requirement: Required
NOTE: For A/B MAC (A) and A/B MAC (HHH), when multiple workloads share a single processing environment, the Contractor ID will reflect the roll-up Contractor ID specified by CMS.

Data Element: Record Type
Definition: Code indicating type of record.
Validation: N/A
Remarks: 3 = Trailer Record
Requirement: Required

Data Element: Record Version Code
Definition: The code indicating the record version of the Claim Resolution file.
Validation: Claim Resolution files prior to 10/1/2007 did not contain this field.
Codes:
B = Record Format as of 10/1/2007
C = Record Format as of 1/1/2010
D = Record Format as of 10/1/2012
E = Record Format as of 7/1/2016
F = Record Format as of 10/1/2017
Remarks: N/A
Requirement: Required

Data Element: Contractor Type
Definition: Type of Medicare Contractor included in the file
Validation: Must be 'A' or 'R'.

Where the TYPE of BILL, 1st position = 3, Contractor Type should be 'R'.
Where the TYPE of BILL, 1st/2nd positions = 81 or 82, contractor Type should be 'R'.
All others will be contractor type 'A'.

Remarks: A = A/B MAC (A) only
R = A/B MAC (HHH) only or both A/B MAC (A) and A/B MAC (HHH)

Requirement: Required

Data Element: Number of Claims
Definition: Number of claim records on this file
Validation: Must be equal to the number of claim records on the file
Remarks: Do not count header or trailer records
Requirement: Required

Claims Provider Address File
Claims Provider Address Header Record (one record per file)

Field Name	Picture	From	Thru	Initialization
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	'1'
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Provider Address Date	X(8)	9	16	Spaces

DATA ELEMENT DETAIL

Data Element: Contractor ID
Definition: Contractor's CMS assigned number
Validation: Must be a valid CMS contractor ID
Remarks: N/A
Requirement: Required
NOTE: For A/B MAC (A) and A/B MAC (HHH), when multiple workloads share a single processing environment, the Contractor ID will reflect the roll-up Contractor ID specified by CMS

Data Element: Record Type
Definition: Code indicating type of record
Validation: N/A
Remarks: 1 = Header record
Requirement: Required

Data Element: Record Version Code
Definition: The code indicating the record version of the Claim Provider Address file
Validation: Claim Provider Address files prior to 10/1/2007 did not contain this field.
Codes:
B = Record Format as of 10/1/2007
C = Record Format as of 1/1/2010
D = Record Format as of 10/1/2012
E = Record Format as of 7/1/2016
Remarks: N/A
Requirement: Required

Data Element: Contractor Type
Definition: Type of Medicare Contractor included in the file
Validation: Must be 'A' or 'R'
Where the TYPE of BILL, 1st position = 3, Contractor Type should be 'R'.
Where the TYPE of BILL, 1st/2nd positions = 81 or 82, contractor Type should be 'R'.
All others will be contractor type 'A'.
Remarks: A = A/B MAC (A) only
R = A/B MAC (HHH) only or both A/B MAC (A) and A/B MAC (HHH)
Requirement: Required

Data Element: Provider Address Date
Definition: Date the Provider Address File was created.
Validation: Must be a valid date not equal to a Provider Address date sent on any previous claims Provider Address file
Remarks: Format is CCYYMMDD. May use shared system batch processing date
Requirement: Required

Provider Address File
Provider Address Detail Record

Field Name	Picture	From	Thru	Initialization
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	Spaces
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Sequence Number	X(1)	9	9	Spaces
Provider Number	X(15)	10	24	Spaces
Provider Name	X(60)	25	84	Spaces
Provider Address 1	X(25)	85	109	Spaces
Provider Address 2	X(25)	110	134	Spaces
Provider City	X(15)	135	149	Spaces
Provider State Code	X(2)	150	151	Spaces
Provider Zip Code	X(9)	152	160	Spaces
Provider Phone Number	X(10)	161	170	Spaces
Provider Phone Number Extension	X(10)	171	180	Spaces
Provider FAX Number	X(10)	181	190	Spaces
Provider Type	X(1)	191	191	Spaces
Provider Address Type	9(3)	192	194	1
Provider E-mail Address	X(75)	195	269	Spaces
Provider Federal Tax number or EIN	9(10)	270	279	Zeroes
Filler	X(16)	280	295	Spaces

DATA ELEMENT DETAIL

Data Element: Contractor ID
Definition: Contractor's CMS assigned number
Validation: Must be a valid CMS contractor ID

Remarks: N/A
Requirement: Required
NOTE: For A/B MAC (A) and A/B MAC (HHH), when multiple workloads share a single processing environment, the Contractor ID will reflect the roll-up Contractor ID specified by CMS

Data Element: Record Type
Definition: Code indicating type of record
Validation: N/A
Remarks: 2 = Detail record
Requirement: Required

Data Element: Record Version Code
Definition: The code indicating the record version of the Claim Provider Address file
Validation: Claim Provider Address files prior to 10/1/2007 did not contain this field.
Codes:
B = Record Format as of 10/1/2007
C = Record Format as of 1/1/2010
D = Record Format as of 10/1/2012
E = Record Format as of 10/1/2017
Remarks: N/A
Requirement: Required

Data Element: Contractor Type
Definition: Type of Medicare Contractor included in the file
Validation: Must be 'A' or 'R'.
Where the TYPE of BILL, 1st position = 3, Contractor Type should be 'R'.
Where the TYPE of BILL, 1st/2nd positions = 81 or 82, contractor Type should be 'R'.
All others will be contractor type 'A'.

Data Element: Sequence Number
Definition: Number occurrence number of addresses when there are multiple addresses for a provider.
Validation: Must be between 1 and 3
Remarks: Enter 1 if there is only one address for a provider
Requirement: Required

Data Element: Provider Number
Definition: Number assigned by Medicare to identify the provider
Validation: N/A
Remarks: Left justify
Requirement: Required

Data Element: Provider Name
Definition: Provider's name
Validation: N/A
Remarks: This is the business name associated with the provider number. Must be formatted into a name for mailing (e. g., Roger A Smith M.D. or Medical Associates, Inc.)
Requirement: Required

Data Element: Provider Address 1
Definition: First line of provider's address
Validation: N/A
Remarks: This is the first line of the address associated with the provider number indicated in the record.
Requirement: Required for all Billing Provider Numbers. Furnish as available for other types of provider numbers.

Data Element: Provider Address 2
Definition: Second line of provider's address
Validation: N/A
Remarks: This is the line of the address associated with the provider number indicated in the record.
Requirement: Required for all Billing Provider Numbers. Furnish as available for other types of provider numbers.

Data Element: Provider City
Definition: Provider's city name
Validation: N/A
Remarks: This is the city of the provider number
Requirement: Required for Billing Provider Numbers. Furnish as available for other types of provider numbers.

Data Element: Provider State Code
Definition: Provider's state code
Validation: Must be a valid state code
Remarks: This is the state associated with the address of the provider number.
Requirement: Required for Billing Provider Numbers. Furnish as available for other types of provider numbers.

Data Element: Provider Zip Code
Definition: Provider's zip code
Validation: Must be a valid postal zip code
Remarks: This is the zip code associated with the address furnished for the provider number identified in this record.
- Provide 9-digit zip code if available, otherwise provide 5-digit zip code.

Requirement: Required for Billing Provider Numbers. Furnish as available for other types of provider numbers.

Data Element: Provider Phone Number
Definition: Provider's phone number
Validation: Must be a valid phone number
Remarks: N/A
Requirement: Required if available

Data Element: Provider Phone Number Extension
Definition: Provider's phone number extension
Validation: Must be a valid phone number
Remarks: N/A
Requirement: Required if available

Data Element: Provider Fax Number
Definition: Provider's fax number
Validation: Must be a valid fax number
Remarks: N/A
Requirement: Required if available

Data Element: Provider Type
Definition: 1=Billing Provider Number (OSCAR)
2=Attending Physician Number (UPIN)
3=Operating Physician Number (UPIN)
4=Other Physician Number (UPIN)
5=Billing Provider NPI
6=Attending Physician NPI
7=Operating Physician NPI
8=Rendering Physician NPI
Validation: Must be 1-8.
Remarks: This field identifies the type of provider number whose name, address, phone number and identification information are included in the record.
Requirement: Required

Data Element: Provider Address Type
Definition: The type of Provider Address furnished.
Validation: 1 = Master Address (FISS)
2 = Remittance Address (FISS)
3 = Check Address (FISS) (APASS)
4 = MSP Other Address (FISS)
5 = Medical Review Address (FISS) (APASS)
6 = Other Address (FISS) (APASS)
7 = Chain Address (APASS)
8 = Correspondence Address
9 = Medical Record Address

Remarks: The first "address type" for each provider will always be a "1." Subsequent occurrences of addresses for the same provider will have the "address type" to correspond to the address submitted. When your files contain only one address for the provider, submit only one provider address record. Submit additional address records for a single provider number only when your files contain addresses that differ from the Master or Legal address.

- Correspondence Address—The Correspondence Address as indicated on the 855A. This is the address and telephone number where Medicare can directly get in touch with the enrolling provider. This address cannot be that of the billing agency, management service organization, or staffing company.
- Medical Record Address—the Location of Patients' Medical Records as indicated on the 855A. This information is required if the Patients' Medical Records are stored at a location other than the Master Address (practice location). Post Office Boxes and Drop Boxes are not acceptable as the physical address where patient's medical records are maintained.

Requirement: Required Billing Provider Numbers. Furnish as available for other types of provider numbers.

Data Element: Provider E-Mail Address

Definition: Provider's e-mail address.
Validation: Must be a valid e-mail address.
Remarks: N/A
Requirement: Required if available.

Data Element: Provider Federal Tax Number or EIN
Definition: The number assigned to the billing provider by the Federal government for tax report purposes. The Federal Tax Number is also known as a tax identification number (TIN) or employer identification number (EIN).
Validation: Must be present
Remarks: N/A
Requirement: Required for all Billing Provider Numbers. For all other types of provider numbers, the tax number is required when available

Data Element: Filler
Definition: Additional space -- use to be determined
Validation: N/A
Remarks: N/A
Requirement: Required

Claims Provider Address File
Claims Provider Address Trailer Record (one record per file)

Field Name	Picture	From	Thru	Initialization
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	'3'
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Number of Records	9(9)	9	17	Zeroes

DATA ELEMENT DETAIL

Data Element: Contractor ID
Definition: Contractor's CMS assigned number.
Validation: Must be a valid CMS contractor ID.
Remarks: N/A
Requirement: Required
NOTE: For A/B MAC (A) and A/B MAC (HHH), when multiple workloads share a single processing environment, the Contractor ID will reflect the roll-up Contractor ID specified by CMS.

Data Element: Record Type
Definition: Code indicating type of record
Validation: N/A
Remarks: 3 = Trailer Record
Requirement: Required

Data Element: Record Version Code
Definition: The code indicating the record version of the Claim Universe file
Validation: Claim Universe files prior to 10/1/2007 did not contain this field.
Codes:

B = Record Format as of 10/1/2007
C = Record Format as of 1/1/2010
D = Record Format as of 10/1/2012
E = Record Format as of 10/1/2017

Remarks: N/A
Requirement: Required

Data Element: Contractor Type
Definition: Type of Medicare Contractor included in the file
Validation: Must be 'A' or 'R'

Where the TYPE of BILL, 1st position = 3, Contractor Type should be 'R'.

Where the TYPE of BILL, 1st/2nd positions = 81 or 82, contractor Type should be 'R'.

All others will be contractor type 'A'.

Remarks: A = A/B MAC (A) only
R = A/B MAC (HHH) only or both A/B MAC (A) and A/B MAC (HHH)
Requirement: Required

Data Element: Number of Records
Definition: Number of provider address records on this file
Validation: Must be equal to the number of provider address records on the file
Remarks: Do not count header or trailer records
Requirement: Required

Exhibit 44 – JOA Appendices

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

Standard Core
Joint Operating Agreement
Between
RACs and *UPICs*

Recovery Audit Contractors (RACs)
Unified Program Integrity Contractors (UPICs)

Revision History Log

Version	Date	Changed By	Description of Change	Approval Required
V01				
V02				

Table of Contents

1. Introduction

1.1. Purpose of this JOA

This Joint Operating Agreement (JOA) is designed to promote cooperation between Recovery Audit Contractors (RACs) and the *Unified Program Integrity Contractor (UPIC)* by establishing and maintaining shared expectations for the interaction among these Parties to the JOA.

1.2. Parties

Parties to the JOA are identified in Appendix Z. Please see Section 2.5 below in this JOA for information regarding completion of this appendix.

1.3. Jurisdictions, Contacts, Roles, and Responsibilities

This information is provided in Appendices B and C. Section 2.2 below in this JOA describes the process for completion of these appendices. Please note that there are multiple tabs in these Microsoft (MS) Excel Workbook appendix files to facilitate use of this information.

1.4. Confidentiality

Given the nature of the work performed by the RAC and the *UPIC*, information contained within this JOA is to be shared only with members of the RAC, *UPIC*, and CMS teams.

1.5. Liability

Although both the RAC and *UPIC* each individually have a contractual relationship with CMS, there is no privity of contract between the RAC and the *UPIC*.

Each contractor will be indemnified and protected by limitations on liability according to the terms of its respective contract with CMS. In light of the provisions of each contractors current contracts with CMS and the constraints of law, no amendments to their respective contracts are made through this JOA with respect to indemnification or limitations on liability.

1.6. Funding

Nothing in this JOA will obligate any parties to perform any tasks that add significant cost and are outside current scope of work unless adequate funding for these tasks is received from CMS.

2. Document Maintenance

2.1. Standard Core JOA

The Standard Core JOA is established and maintained by CMS to apply standardized best practices for the interaction between the RAC and *UPIC* contractors. This Standard Core JOA is purposely designed so that it does not need to reflect contractor specific information, which is instead contained in the JOA Appendix Documents. This JOA should not be modified from the standard without consulting with the TO COTRs.

2.2. JOA Appendices

List of Appendices – Appendix A lists all JOA appendices, identifies the name of the team responsible for collecting and incorporating updates, and briefly describes how each appendix is to be created and maintained.

Distributed Update Responsibilities – Appendix documents are separated to facilitate maintenance.

The Contact List, for example, is divided into separate files by team so that each team can make and distribute updates to their list without having to coordinate input from other teams. If a contractor holds multiple contracts with CMS and if this contractor wants a separate Contact List for each contract to facilitate updates by different teams, this is allowed. The multiple tabs within each Contact List Excel Workbook facilitate differentiation between multiple task orders on a single contract.

Use Across Multiple JOAs – The templates for these appendix documents, such as the Contact List templates, have been formatted so that they can be applied to multiple JOAs, eliminating the need to maintain similar/duplicate information across multiple JOAs.

Document Owner – The name of the individual person on each team who will update each appendix will be identified by that team at the top of each of their appendix documents. This facilitates identification of the person to whom updates should be sent.

Templates – CMS provides a standard template for each appendix which can be amended by each party if necessary to effectively convey the information for their team. To promote consistency, please apply the standard template to the greatest degree practical.

2.3. Required Roles

To promote proper direction of communication, each RAC and *UPIC* will identify, in its Contact List, a Primary and an Alternate for each of the following Required Roles:

- JOA POC – Joint Operating Agreement Point of Contact – This individual is responsible for serving as the lead contractor point of contact in establishing and maintaining the JOA content and in leading the resolution of any JOA-related issues that may arise.

- JOA Approver – One individual from the RAC and one individual from the *UPIC* will be identified to approve the JOA.

- Operational Lead – This individual is responsible for serving as the lead point of contact in performing ongoing operational work under the terms of the JOA. This standard title is used in the JOA because various teams use different titles for the individuals that they have serving in this role, and the JOA can not effectively incorporate all of those titles. Each party will identify their Operational Lead in their Contact List, and they are welcome to add in the Contact List any other appropriate titles for this individual as well.

2.4. Managing Change

Change Suggestions – Recommendations for updates to JOA documents are encouraged and are to be sent to the Document Owner.

Revision History – Each Document Owner is to identify changes to JOA documents in the Revision History Log.

Version Number – The version number is used to make sure that everyone is looking at the same version of a document. The Document Owner is to increment the JOA version number each time the JOA is sent out for approval. Multiple updates can be consolidated into the same version number. The version number is imbedded as the last characters (ex: V01) of each file name.

Process Note: In MS Excel, updates to the version number in the file name are automatically propagated to the top of each printed Excel document. In MS Word, select "File, Print Preview" when the version number in the file name is updated to cause the updated version number to be propagated from the file name to the top of the document.

2.5. Approval of Standard Core JOA

CMS Approval of All Versions of the JOA

- CMS will solicit input, make updates, distribute, and refine this Standard Core JOA as necessary. Through this cycle of change, CMS will have reviewed and approved all updates.

RAC and *UPIC* Approval of the First JOA

- CMS directs that all Parties to the JOA (the RAC and *UPIC*) are to sign (using hand written signature) the first jointly approved version of the JOA.

- To accomplish this, the JOA Approvers are to hand-write their signature on two copies of Appendix Z, the JOA Approval Form, which they are then to mail (one copy each) to the primary RAC JOA POC and *UPIC* TO COTR who are responsible for their retention and for providing a copy of these upon request.

- To facilitate communication of status, the JOA Approvers are also to send out an email to these individuals indicating that they have approved the JOA.

RAC and *UPIC* Approval of Ongoing Updates

- As CMS makes subsequent updates to the Standard Core JOA, CMS will advise contractors via Email if the new version is sufficiently changed to require approval. CMS will also update the last column of the Revision History table of the JOA to keep a record of which versions require approval.

- A hand written signature is not required for ongoing updates. Instead, an electronic signature (an electronic copy of the approver's signature) is to be used as the signature.

- To provide approval for ongoing updates, the JOA Approver is to fill out Appendix Z, paste in their electronic signature, and then send this completed document via email to the Primary and Alternate JOA POC for the RAC and *UPIC* TO COTR. The Primary JOA POCs and TO COTRs are responsible for retaining these emails and for providing a copy of these upon request.

No Approval Required on Appendix Updates – No approval is required on updates to the appendices.

Timing of Approvals – Parties are to provide approval within 10 business days of receipt of an updated Standard Core JOA. If parties have an issue with the JOA, they are to raise this issue within 10 business days. If no issues are identified before the end of this period, the JOA updates will be considered approved.

Distribution – Each JOA POC will disseminate information regarding the update within their organization.

3. Communication

Communication is a crucial component that will occur at multiple levels using multiple tools and techniques as described below.

3.1. JOA Checkpoint Meetings

Purpose – These meetings provide a forum for communication on topics of mutual interest among the Parties to the JOA. Topics will include a discussion of any issues with coordination among the parties the status of any changes to the JOA documents.

Location – These meetings will most often take place via conference call. In those instances where a RAC and a *UPIC* are located close enough to allow a short drive, some participants may join in-person.

Frequency – The meetings will occur at minimum on a quarterly basis for the first year after the signing of the first JOA and then at least semi-annually thereafter.

Meeting Dates – CMS representatives need to attend multiple of these meetings across contractors, so CMS will work with contractors to coordinate spreading of these meetings over time. At the conclusion of each meeting, the participants will determine mutually agreeable timing (and location where appropriate) for the next meeting; information that will then be confirmed via email. Changes will be communicated through the JOA POC via email.

Facilitation – Responsibility for facilitating the meeting will rotate between the RAC and the *UPIC*. This will include preparation of the agenda, providing a dial in number, facilitating the discussion, and capturing and distributing meeting minutes.

Meeting Minutes – Are to be distributed within five business days of the meeting and should clearly identify Action Items for review in the next meeting.

Participation – Invitees are to minimally include the applicable CMS COTRs and the Primary and Alternate JOA POC. The JOA POC will invite other participants as appropriate.

3.2. Other Workgroup Meetings

Purpose – In addition to the JOA Checkpoint meetings, the Parties to the JOA will interact on a regular basis in smaller workgroups to address specific needs.

Location, Timing, and Facilitation –Will be similar to the Checkpoint Meetings.

Formation – Recommendations for new workgroups should be considered at the JOA Checkpoint Meetings.

3.3. Issue Escalation and Resolution Process

Issues will be escalated if necessary for resolution via the following process:

1. Source – The RAC and the *UPIC* individuals identifying the issue will work with their counter-parts first to attempt to resolve the issue.

2. JOA POCs – If they are unable to come to a resolution, the matter will be brought to the attention of the RAC Contractor JOA POC and the *UPIC* JOA POC (identified in the Contractor Contact List Appendices).

3. Operational Leads – If they are unable to come to a resolution, the matter will be escalated to the RAC Operational Lead and the *UPIC* Operational Lead (identified in the Contractor Contact List Appendices).

4. CMS Contract Officer Technical Representatives (COTRs) – If they are unable to come to a resolution, the Operational Leads will bring the matter to the attention of the CMS COTRs (identified in the CMS Contact List Appendices).

5. JOA Alternative Dispute Resolution (ADR) Team – In the event the dispute between the RAC and the *UPIC* cannot be resolved, the issues will be directed in writing to the CMS RAC and *UPIC* Contracting Officers, Project Officers, and COTRs for resolution by the JOA ADR) team. The ADR team will issue a written determination to both the RAC and the *UPIC*.

Timing of Issue Escalation and Resolution – The speed with which issues are escalated and resolved will be dependent on the priority of the issue, with higher impact issues receiving quicker attention by all parties. As a general guideline, parties should endeavor to resolve or escalate an issue within 1-3 days of its receipt, or they should reply to all parties to advise them of the reasons for additional time needed for action.

3.4. Non-Compliance

If a party does not comply with a provision of the JOA, notification and resolution will take place as follows:

1. Notification – If a party does not comply with a provision of the JOA, the Operational Lead for that party will notify the Operational lead for the other party.

2. Resolution – A non-compliance is often one-time event with no significant impact which can often be quickly resolved and prevented in the future through the interaction of the Operational Leads. In these circumstances, escalation is not required.

3. Escalation – If a non-compliance creates an impact that either party feels requires escalation either for notification purposes or for issue resolution purposes, then the

Operational Leads will notify the CMS COTRs. If necessary, the ADR process described above will be applied to achieve closure.

3.5. Communication Regarding CMS Changes

As part of ongoing operations, the RAC and the *UPIC* Contractor staff will both review documents received from CMS, including Transmittals, Program Memoranda, Change Requests and Notes. The RAC and the *UPIC* Contractor will continue to determine their own operational impact and will provide comments and escalate issues to CMS independently, as appropriate.

All issues that are determined to have an impact on any RAC or *UPIC* Contractor operations included in this JOA will be submitted to the RAC and *UPIC* JOA POCs for discussion at the next JOA Checkpoint Meeting, or sooner if appropriate.

3.6. Securing Email Information

CMS has indicated that it is not appropriate to send emails containing beneficiary or provider identifiers (including names and numbers) even if those identifiers are contained within a password- protected attachment. Each JOA Participant is responsible for obtaining, understanding, interpreting, and implementing its own policies and procedures regarding use of email containing beneficiary or provider identifiers. CMS Secure Email may be used to send protected information to CMS and other users of this email system. If Secure Email is not available, send this information via an encrypted CD through registered mail.

4. Identification and Action on Fraudulent Behavior

4.1. Identification and Notification of Fraud by the RAC

RAC Responsibility – When the RAC encounters an issue that meets the criteria of potential fraud, the RAC will notify the RAC PO who will forward this to the Director of the Division of Benefit Integrity Management Operations.

Indicators of Fraud – The following are indicators of fraud that must be reported to the RAC PO. The RAC should use their best judgment to determine if other findings may constitute fraudulent behavior. Section 6.2 of this Standard Core JOA provides information regarding training for the RAC staff to identify fraud.

- Submission of false claims
- Services being rendered by unlicensed individuals
- Ordered services being provided without a legitimate physician order
- Claims for beneficiaries or providers that are deceased
- Non-compliance with medical record requests

4.2. Coordination with Law Enforcement

The *UPIC* will interact with Law Enforcement related to potential fraudulent activity. The RAC must not contact Law Enforcement with fraud suspicions; they must contact the RAC PO. Law enforcement may contact the RAC with recovery inquiries but any other LE RFIs shall be referred by the RAC directly to the *UPIC*.

4.3. High Risk Areas

CMS may identify High Risk areas within a *UPIC* jurisdiction. These are areas that are known to have wide-spread fraud. The *UPICs* are required to take aggressive, rapid and innovative measures to curtail fraud in these areas and this may impact the RAC's ability to perform audits in these areas. The *UPIC* will have the ability, in High Risk Areas, to suppress providers in order to protect the *UPIC* and Law Enforcement's ability to identify, prevent and prosecute fraudulent activities.

5. Training

5.1. Training provided by the *UPIC*

Purpose – Fraud detection and awareness training will be provided to assist the RAC in identifying fraudulent behavior, including indicators that RAC staff should look for and examples of real fraud scenarios.

Audience – This training is designed for members of the RAC team.

Initial and Annual Training – The *UPIC* will provide this training at the start of working together as contractors and on at least an annual basis thereafter.

New Employee Training – The RAC will be responsible to provide this on-going training for new RAC employees throughout the year using the materials provided by the *UPIC*.

Participation Requirement – Training participation is required to at least one session per year to be provided by the *UPIC*. *UPICs* can rotate the responsibility for training and must avoid duplication across contracts.

Training on Changes – Additional training will be provided by the *UPIC* when substantive changes are identified in fraud detection and awareness.

Exhibit 45 – *UPIC* Prepayment and Postpayment Notification Letter

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

DATE:
PROVIDER NAME:
PROVIDER ADDRESS:
PROVIER NUMBER:

UPIC NAME/*JURISDICTION*:
UPIC CONTACT/PHONE NUMBER:
UPIC ADDRESS:

Dear Provider Name:

As a Medicare contractor, the *Unified Program Integrity Contractor (UPIC)* is required by the Centers for Medicare & Medicaid Services (CMS) to analyze claims payment data in order to identify areas with the greatest risk of inappropriate program payment. Specifically, as a (indicate *UPIC*), (write *UPIC* Name) is required to investigate situations of potential fraud, waste, and abuse.

Your claims have been selected for a comprehensive medical review of your billing for Medicare services pursuant to CMS' statutory and regulatory authority. You were selected for this review because our analysis of your billing data indicates that there may be aberrancies in your billing.

We have selected claims for services provided during the period_____through_____. You will subsequently receive a request for medical records, which will explain the specific documentation that is being requested. If you have any questions regarding the letter requesting medical records/documentation, please contact (*UPIC* Contact's Name) at (Phone Number of *UPIC* Contact).

Thank you for your prompt response to the request for medical records/documentation.