CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1625	**Date: February 5, 2016**
	Change Request 8913

Transmittal 1483, dated March 31, 2015, is being rescinded and replaced by Transmittal 1625, dated February 5, 2016, to make consistent with direction given in CR 9215, specifically updates were made to BR 8913.2. All other information remains the same.

SUBJECT: Identifying "No Documentation" Medical Necessity Denials for Claims Flagged for Recovery Auditor Review

I. SUMMARY OF CHANGES: The purpose of this Change Request is to provide a Recovery Audit specific "No documentation" reason code for Medicare Administrative Contractors to append to prepayment claim denials.

EFFECTIVE DATE: July 1, 2015
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 6, 2015 - Define/Analyze and Design Application; October 5, 2015 - Hours for Code Development/Test and Alpha Testing

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

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	N/A

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:

One Time Notification

Attachment - One-Time Notification

Pub. 100-20	Transmittal: 1625	Date: February 5, 2016	Change Request: 8913

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SUBJECT: Identifying "No Documentation" Medical Necessity Denials for Claims Flagged for Recovery Auditor Review

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I. GENERAL INFORMATION

A. Background: The Recovery Audit Program has recently undertaken a prepayment review demonstration. In order for contractors other than the Medicare Administrative Contractor (MAC) to conduct prepayment medical review, the MAC must create an edit that flags the claim for review, and sends an Additional Documentation Request (ADR) to the provider, requesting them to send the medical record directly to the contractor conducting the review—in this case the Recovery Auditor. MACs then receive periodic updates from the Recovery Auditor to alert them that the medical records have been received for the claims flagged for review. The MAC will move all claims in which the medical record was received to a "hold" location in the shared system, pending the review results from the Recovery Auditor. Any claims for which the medical record is not received timely will deny based on an automated technical edit, that the medical record was not received prior to, or on day 45. The current editing structure denies the claim using code 56900 (which indicates the claim for payment is not medically necessary) The MAC is requesting that CMS provide an alternate, synonymous denial structure, which will additionally identify the auto-denial for no documentation as related to a Recovery Auditor review.

B. Policy: Section 302 of the Tax Relief Act and Health Care Act of 2006.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
8913.1	FISS shall create a daily file to be sent to the Recovery Auditors providing data for claims that have had ADRs generated for their review. **NOTE**: This file format will include the DCN, HIC, DOS, and Provider/NPI.					X				
8913.1.1	The VDC shall send the file created in BR 8913.1 to the appropriate Recovery Auditor Region.									VDC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
8913.1.1.1	The VDC shall also send the file created in BR 8913.1 to the respective MAC.									VDC
8913.1.2	Recovery Audit Contractors shall be prepared to receive the daily file as well as be prepared for testing phases with FISS, the STC and the MAC.	X				X				RACs
8913.1.3	The Recovery Audit Contractor shall use the confirmed file format attached for the creation of the file in BR 8913.1, which includes the DCN, HIC, DOS, and Provider/NPI.					X				
8913.2	Contractors shall ensure that Reason Code 56900 has the following ANSI coding assigned: CARC 50, Group Code CO and Appeal Code MA01.	X								
8913.3	FISS shall create separate electronic monthly reports of all the automated claim denials for "No Documentation" being sent to the Recovery Auditor, sorted by Recovery Audit region. (Recovery Audit Regions A-D, 1-5).					X				
8913.3.1	Recovery Audit Contractors shall be prepared to receive the monthly reports as well as be prepared for testing phases with FISS, the STC and the MAC.	X				X				RACs
8913.3.2	FISS shall use the confirmed report format attached for the creation of the report in BR 8913.3.					X				
8913.4	FISS shall add a claim level field on the claim record to store the PIMR Activity Code.					X				
8913.5	FISS shall display the new field on the on-line claim screen.					X				
8913.6	FISS shall move the value in the PIMR Activity Code field on the Reason Code File to the new field created in BR 8913.4.					X				
8913.7	The VDC shall send the monthly report created in BR 8913.3 to the Recovery Auditor to the appropriate Recovery Auditor region.									VDC

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): Ashley Ford, 410-786-0828 or Ashley.Ford@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: 2

Daily File Copybook

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01   RA   RC-CLM-OUTPUT-REC.
     05   RAC-CLM-BDL-LETTER-CD OCCURS 10 TIMES          PIC X(05) VALUE SPACES.
     05   RAC-CLM-ADR-ORIG-REQ-DT-CYMD                   PIC X(08) VALUE SPACES.
     05   RAC-CLM-DCN                                    PIC X(23) VALUE SPACES.
     05   RAC-CLM-MEDA-PROV-ID                           PIC X(13) VALUE SPACES.
     05   RAC-CLM-NPI-NUMBER                             PIC X(10) VALUE SPACES.
     05   RAC-CLM-PROV-NAME                              PIC X(31) VALUE SPACES.
                                                          increased from 23 to 31
     05   RAC-CLM-CARRIER-CD-ID                          PIC X(05) VALUE SPACES.
     05   RAC-LOCALITY-CD-ID                             PIC X(02) VALUE SPACES.
     05   RAC-CLM-STMT-COV-FROM-DT-CYMD                  PIC X(08) VALUE SPACES.
     05   RAC-CLM-STMT-COV-TO-DT-CYMD                    PIC X(08) VALUE SPACES.
     05   RAC-CLM-PAT-CNTRL-NO                           PIC X(20) VALUE SPACES.
     05   RAC-CLM-HIC                                    PIC X(12) VALUE SPACES.
     05   RAC-CLM-BENE-LAST-NAME                         PIC X(15) VALUE SPACES.
                                                          increased from 13 to 15
     05   RAC-CLM-BENE-FIRST-NAME                        PIC X(10) VALUE SPACES.
     05   RAC-CLM-BENE-DOB                               PIC X(08) VALUE SPACES.
     05   RAC-CLM-BENE-SEX                               PIC X(01) VALUE SPACES.
     05   RAC-CLM-INTERMEDIARY-NB                        PIC X(05) VALUE SPACES.
     05   RAC-CLM-CLM-TYP-IND                            PIC X(01) VALUE SPACES.
     05   RAC-CLM-TOTAL-CHARGE-AMOUNT                    PIC 9(09)V99 VALUE ZEROS.

     05   RAC-CLM-PRINCIPLE-DIAG                         PIC X(07) VALUE SPACES.
     05   RAC-CLM-DIAG-CD-2 OCCURS 25 TIMES.
          10  RAC-CLM-DIAG-CD2-OTH                      PIC X(07) VALUE SPACES.
     05   RAC-CLM-DIAG-POA-IND  OCCURS 25 TIMES          PIC X(01) VALUE SPACES.
     05   RAC-CLM-EXT-INJURY-DIAG-CODE                   PIC X(07) VALUE SPACES.
     05   RAC-CLM-PROC-CD  OCCURS 25 TIMES               PIC X(07) VALUE SPACES.
     05   RAC-CLM-PROC-DT-CYMD OCCURS 25 TIMES           PIC X(08) VALUE SPACES.
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05  RAC-CLM-COND-CD  OCCURS 30 TIMES                          PIC X(02) VALUE SPACES.
05  RAC-CLM-OCCUR-CD  OCCURS 30 TIMES                         PIC X(02) VALUE SPACES.
05  RAC-CLM-OCCUR-DT-CYMD  OCCURS 30 TIMES                    PIC X(08) VALUE SPACES.
05  RAC-CLM-OCCUR-SPAN-CD  OCCURS 10 TIMES                    PIC X(02) VALUE SPACES.
05  RAC-CLM-OCCUR-SPAN-FRM-DT-CYMD  OCCURS 10 TIMES           PIC X(08) VALUE SPACES.
05  RAC-CLM-OCCUR-SPAN-TO-DT-CYMD  OCCURS 10 TIMES            PIC X(08) VALUE SPACES.
05  RAC-CLM-VALUE-CODE-AMT  OCCURS 36 TIMES
    10  RAC-CLM-VAL-CD                                        PIC X(02) VALUE SPACES.
    10  RAC-CLM-VAL-AMT                                       PIC 9(07)V99 VALUE ZEROS.
05  RAC-CLM-DRG-CD                                            PIC X(03) VALUE SPACES.
05  RAC-CLM-BILL-TYP-CD                                       PIC X(03) VALUE SPACES.
05  RAC-CLM-PATIENT-STATUS                                    PIC X(02) VALUE SPACES.
05  RAC-CLM-ADM-SOURCE                                        PIC X(01) VALUE SPACES.
05  RAC-CLM-ORIG-PROV-REIMB                                   PIC 9(09)V99 VALUE ZERO.
05  RAC-CLM TREAT-AUTH-CD                                     PIC X(18) VALUE SPACES.
05  RAC-CLM-LINES-TOTAL                                       PIC 9(03) VALUE ZERO.
05  FILLER                                                    PIC X(41) VALUE SPACES.
05  RAC-CLM-LINE-ITEMS OCCURS 100 TIMES.
    10  RAC-CLM-REV-CD                                        PIC X(04) VALUE SPACES.
    10  RAC-CLM-HCPC-CD                                       PIC X(05) VALUE SPACES.
    10  RAC-CLM-HCPC-MODIFIERS                                PIC X(10) VALUE SPACES.
    10  RAC-CLM-SERV-DT-CYMD                                  PIC X(08) VALUE SPACES.
    10  RAC-CLM-REV-TOT-CHRG-AMT                              PIC 9(09)V99 VALUE ZERO.
    10  RAC-CLM-REV-NCOV-CHRG-AMT                             PIC 9(09)V99 VALUE ZERO.
    10  RAC-CLM-PROV-REIMB-LINE                               PIC 9(09)V99 VALUE ZERO.
    10  RAC-CLM-LINE-REASON                                   PIC X(05) VALUE SPACES.
    10  RAC-CLM-REV-UNITS-BILLED                              PIC S9(09)  VALUE ZERO.
    10  RAC-CLM-REV-SERV-UNIT-CNT                             PIC S9(09)  VALUE ZERO.
    10  RAC-CLM-IDE-NUMBER                                    PIC X(15) VALUE SPACES.
    10  RAC-CLM-APC-HCPCS-APC                                 PIC 9(05)  VALUE ZERO.
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10  RAC-CLM-LINE-OCE-FLAGS
    15  RAC-CLM-APC-SERV-IND                PIC X(02) VALUE SPACES.
    15  RAC-CLM-APC-PAYMENT-IND             PIC X(02) VALUE SPACES.
    15  RAC-CLM-APC-DISC-FCTR               PIC X(01) VALUE SPACES.
    15  RAC-CLM-APC-DEN-REJ                 PIC X(01) VALUE SPACES.
    15  RAC-CLM-APC-PKG-FLAG                PIC X(01) VALUE SPACES.
    15  RAC-CLM-APC-PAY-ADJ-FLAG            PIC X(02) VALUE SPACES.
    15  RAC-CLM-APC-TOB-INCL                PIC X(01) VALUE SPACES.
    15  RAC-CLM-APC-ACTION-FLAG             PIC X(01) VALUE SPACES.
    15  RAC-CLM-COMPOSITE-ADJ-FLAG          PIC X(02) VALUE SPACES.
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Header Layout

Field Name	Location	Length	Attributes	Sample	Valid Values and Notes
File Type	1	10	AN-10	CLAIM	Value: "Claim" Left justified, space fill
Filler	11	1	AN-1		Space fill
File Format Version	12	3	AN-3	4	Value: 004
Filler	15	1	AN -1		Space fill
Record Count	16	6	Num-6	102	Number of records contained in file. Right justified, zero fill
Filler	22	1	AN-1		Space fill
Record Length	23	3	Num-3	128	128
Filler	26	1	AN -1		Space fill
Create Date	27	8	Num-8	20090617	File Creation Date Format = YYYYMMDD
Filler	35	7	AN -7		Space fill
Source ID	42	5	AN-5		Values = Contractor ID of the user who created the file. Left Justified

Filler	47	1	AN-1		Space fill
MAC Workload Number	48	5	Num- 5	12345	Workload Number
Filler	53	75	AN-1	R	Space fill
Text Delimiter	128	1	AN-1		Text Delimiter

Claim Record Layout

Field Name	Start	End	Length / Attributes	Required / Situational	Description - Valid Values and Notes
Record Type	1	1	1-AN	R	Claim Record-C
Claim Type	2	2	1-A	R	NCH MQA Record Identification Code 1 = Inpatient 2 = SNF 3 = Hospice 4 = Outpatient 5 = Home Health Agency 6 = DDE 7 = Professional
Out-of-Jurisdiction Flag	3	3	1-A	S	Use a space.
State Code for the provider	4	5	2-A	R	State Codes: ME, CA

Place of Service ZIP Code	6	10	5-AN	R	US Postal Code where service rendered.
Contractor ID	11	15	5-AN	R	Claims processing contractor ID number
Original Claim ID	16	38	23-AN	R	Unique identifier number assigned by Carrier, Fiscal Intermediary, A/B MAC or DME MAC to claim For Claim Type 1 through 5 - length must be equal to or greater than 14. For Claim Type 6 - length must be 15. For Claim Type 7 - length must be 14.
Type of Bill	39	42	4-AN	R/S	* Required for Claim Type 1 - 5. (left justified)
Provider Legacy Number	43	55	13-AN	S	Unique Provider Legacy Number of the provider that performed the service and filed the claim.
Provider NPI	56	65	10-AN	R	Unique Provider NPI of the provider that performed the service and filed the claim
DME Ordering Provider NPI	66	75	10-AN	S	NPI of Provider that prescribed the supplies.
Filler	76	92	17-AN	Filler	Spaces
Date of Service Start (statement covers from date)	93	100	8-N	R	Date service started/performed YYYYMMDD
Date of Service End (statement covers thru date)	101	108	8-N	R	Date service ended YYYYMMDD

Provider Type	109	110	2-AN	R	Type of Provider or Supplier Valid Values: 1 = Lab/Ambulance 2 = Outpatient Hospital 3 = Home Health (HHA) 4 = Hospice 5 = Professional Services (physician/non-physician practitioner) 6 = DME by Supplier 7 = Skilled Nursing (SNF) 8 = Inpatient Hospital 9 = Inpatient Rehabilitation (IRF) 10 = Critical Access Hospital (CAH) 11 = Long Term Care Hospital (LTCH) 12 = DME by Physician 13 = Ambulatory Surgery Center (ASC) 14 = Other
CMS Provider Specialty Code	111	112	2-AN	S	CMS Provider Specialty Code in Carrier/DME files; no equivalent in institutional files
Review Type	113	114	2-AN	R	

					Pre-Payment Review-PR
Date Chosen for Prepayment Review	115	122	8-N	R	Date format YYYYMMDD (Date it goes to SB6000 or SB6001)
PIMR Activity Code	123	124	2-AN	R	XA-XD or X1-X5
Text Delimiter	125	125	1-an	Delimiter	Text delimiter

Claim Line Item Record Layout

Field Name	Start	End	Length / Attributes	Required / Situational	Description - Valid Values and Notes
Record Type	1	1	1-AN	R	Line-L
Line item number	2	4	3-AN	R	Claim line item number; 000 for institutional claims. If line number = 000, then no other lines are acceptable for that claim
Original Diagnosis Code Version Indicator	5	5	1-N	R	9 for ICD-9 or 0 for ICD-10;
Original Principal Diagnosis Code (institutional)	6	12	7-AN	R	Original ICD-9 or ICD-10. Decimal point(.) is not allowed.
Original DRG	13	15	3-AN	S	Original DRG on claim. It must be three digit numbers. Line 000 only

Original ICD Primary Procedure Code	16	22	7-AN	S	Original ICD9/ICD10 Procedure Code on RAC identified claim. Decimal point(.) is not allowed.
Original Non-DRG PPS/Hospice LOC Code	23	27	5-AN	S	Original HOPPS code for outpatient hospitals (APCs), HIPPS code for SNFs (RUG/AIs), HHAs (HHRGs) or IRFs (CMG/RICs), or Level of Care code for hospice claims.
Original HCPCS	28	32	5-AN	S	Original HCPCS on claim. Not generally used for inpatient claims (exceptions do exist)
Original Units of Service	33	35	3-N	S	Original units of service on claim
Prior Authorization (PA) Program Indicator	36	39	4-AN	S	This field identifies the PA Program – change made by CR9017
Filler	40	124	85-AN	R	Spaces
Text Delimiter	125	125	1-AN		Text Delimiter