CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 229	Date: NOVEMBER 23, 2007
	Change Request 5760

SUBJECT: Medical Review Strategy and Strategy Analysis Report

I. SUMMARY OF CHANGES: Contractors shall submit a medical review strategy and a Strategy Analysis Report to CMS via the MR system located at CMS"s local coverage system portal Web site.

NEW / REVISED MATERIAL
EFFECTIVE DATE: APRIL 1, 2008
IMPLEMENTATION DATE: APRIL 7, 2008

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	1/1.2.3/Annual MR Strategy
R	1/1.2.3.5/Budget and Workload Management
R	1/1.2.3.6/Staffing and Workforce Management
R	7/7.8/The Strategy Analysis Report (SAR)

III. FUNDING:

SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

SECTION B: 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
Unless otherwise specified, the effective date is the date of service.

Attachment - Business Requirements

Pub. 100-08	Transmittal: 229	Date: November 23, 2007	Change Request:

SUBJECT: Medical Review Strategy and Strategy Analysis Report

EFFECTIVE DATE: APRIL 1, 2008

IMPLEMENTATION DATE: APRIL 7, 2008

I. GENERAL INFORMATION

A. Background: Contractors are required to submit a medical review strategy and Strategy Analysis Report each year. In the past, the reports were prepared as a document and submitted to CMS via e-mail. Contractors will prepare and submit the reports via the MR system located at CMS's local coverage systems portal Web site.

B. Policy: Contractors must review services specific and provider specific claims. The use of OSCAR and NPI numbers assist the contractors in performing this function.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
5760.1	Contractors shall prepare a medical review strategy every fiscal year.	X	X	X	X	X					MR PSC
5760.2	Contractors shall submit the medical review strategy via the MR system located at CMS's Local Coverage System Portal Web site.	X	X	X	X	X					MR PSC
5760.3	Contractors shall prepare a Strategy Analysis Report every year.	X	X	X	X	X					MR PSC
5760.4	Contractors shall submit the Strategy Analysis Report via the MR system located at CMS's Local Coverage System Portal Web site.	X	X	X	X	X					MR PSC

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)

		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
5760.1	None.										

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

B. For all other recommendations and supporting information, use this space:

V. CONTACTS

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VI. FUNDING

A. *For Fiscal Intermediaries, Carriers, and the Durable Medical Equipment Regional Carrier (DMERC)*:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

B. *For Medicare Administrative Contractors (MAC)*:
The Medicare administrative contractor (MAC) is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as changes to the MAC Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts specified 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.

1.2.3 - Annual MR Strategy

(Rev. 229, Issued: 11-23-07, Effective: 04-01-08, Implementation: 04-07-08)

Each fiscal year, the contractors shall develop and document a unique annual MR strategy within their jurisdiction. This strategy must be consistent with the goal of reducing the claims payment error rate.

The MR strategy shall detail identified MR issues, activities, projected goals, and the evaluation of activities and goals. It must be a fluid document that is revised, as targeted issues are successfully resolved, and other issues take their place. The initial strategy submitted at the beginning of the fiscal year shall be based on the strategy from the current fiscal year and updated and expanded upon as necessary.

The contractor shall analyze data from a variety of sources in the initial step in updating the MR strategy. The contractor shall use their CERT findings as the primary source of data to base further data analysis in identifying program vulnerabilities. CERT is only a pointer and cannot be relied upon as a single source of information. Contractors should use their internal data to verify that the CERT findings are (or are not) currently problems of sufficient magnitude to be included in their MR strategy in the appropriate priority. Other problems identified from other sources may be of higher priority, but contractors must review the CERT findings in terms of their own data and MR activities. Other data sources can include, but are not limited to, information gathered from other operational areas, such as appeals and inquiries, that interact with MR and Provider Outreach and Education POE.

After information and data is gathered and analyzed, the contractor shall develop and prioritize a problem list. A problem list is a list of the program vulnerabilities that threaten the Medicare Trust Fund that can be addressed through MR activities. The contractor shall consider resources and the scope of each identified medical review issue, when prioritizing their problem list. In addition, the contractor shall identify and address, in the problem list, work that is currently being performed and problems that will carry over to the following fiscal year. Once a problem list is created, the contractor shall develop MR interventions using the PCA process (IOM Pub 100-8, chapter 3, section 14) to address each problem.

The methods and resources used for MR interventions depend on the scope and severity of the problems identified and the action needed to successfully address the problems. For example, if initial MR actions such as an MR notification letter to the provider and placement on prepayment review are insufficient to improve the provider's billing accuracy, a priority referral to POE for potential intervention may be necessary. Alternately, if on initial probe, a medium or high priority problem is identified, MR may determine that the initial issuance of probe result letter is insufficient, and a priority referral to POE, and/or more intensive medical review corrective actions may be required. A priority referral is an indication to the POE department that this is a problem which MR has determined will likely require further educational intervention. If, through communication with POE, it is determined that MR intervention and POE educational

efforts have not effectively resolved the problem, a referral to the PSC BI unit may be indicated.

In addition, all claims reviewed by medical review shall be identified by MR data analysis and addressed as a prioritized problem in the MR strategy and reflected in the SAR. If resources allow, an MR nurse may be shared with another functional area, such as claims processing, as long as only the percentage of the nurses time spent on MR activities is identified in the strategy and accounted for in the appropriate functional area. For example, if MR agrees to share 0.5 of an FTE with claims processing to assist with the pricing of NOC claims, this 0.5 FTE shall be accounted for in claims processing.

The contractor shall develop multiple tools to effectively address identified problems for the local Medicare providers. The MR strategy shall include achievable goals and evaluation methods that test the effectiveness and efficiency of activities designed to resolve targeted medical review problems. These evaluation methods will be dependent upon effective communication between the MR and POE departments. MR shall work with POE to develop an effective system of communication regarding the disposition of problems referred to POE. Within MR, a system shall be used to track referrals to POE, follow-up communication with POE, and MR interventions used to address identified problems. The PSC shall include what information is required in the referrals to POE within the AC or MAC JOA.

As problems are addressed within MR or referred to POE, the MR department shall incorporate processes for follow-up that ensure appropriate resolution of the issue. If aberrancies continue, the contractor shall use the information gathered through communication with POE to determine a more progressive course of action, such as increase in prepay MR, priority referral to POE, or referral to BI in cases of suspected fraud. Effective tracking of MR and POE efforts to resolve identified problems is integral to development of any case referred for potential investigation by the PSC (See PIM, chapter 4, section 4.3). As issues are successfully resolved, the contractor shall continue to address other program vulnerabilities identified on the problem list.

The MR strategy shall include a section that describes the process used to monitor spending in each CAFM II Activity Code. The process shall ensure that spending is consistent with the allocated budget and include a process to revise or amend the plan when spending is over or under the budget allocation. In addition, the strategy shall describe how workload for each CAFM II Activity Code is accurately and consistently reported. The workload reporting process shall also assure the proper allocation of employee hours required for each activity. Program safeguard contractors (PSC) *and Medicare administrative contractors (MACs)* shall not report cost and workload using the CAFM II system. Instead, the contractor shall report cost and workload in the CMS analysis, reporting, and tracking (ART) system.

In each element of the MR strategy, the contractor shall incorporate quality assurance activities as described below. Quality assurance activities ensure that each element is being performed consistently and accurately throughout the contractor's MR program. In

addition, the contractor shall have in place procedures for continuous quality improvement. Quality Improvement builds on quality assurance in that it allows the contractor to analyze the outcomes from their program and continually improve the effectiveness of their processes.

In order to assist contractors in developing their strategies, the CMS has developed the following generic template that can be used to help guide contractor planning and ensure that all activities and expected outcomes are reported. Examples of actions which might be listed in the intervention list include, but are not limited to service-specific probes, notification letters, POE priority referrals, and automated denials based on LCDs**.**

Figure 1

FY 200_ Medicare Medical Review Strategy

Contractor Name:
Contractor Number:
Contractor MR site location(s):

Data Analysis Plan:
Prioritized Problems: **(1)**
(2)
(3)
Intervention Plan: **(1)**
(2)
(3)
Follow up Plan: **(1)**
(2)
(3)
Program Management:

- **Workload management process**
- **Cost allocation management process**
- **Staffing & Resource management process**
- **CMS Mandates**
- **PSC support**

Budget and Workload Chart:

Staffing Chart:

List all the problems identified and prioritize them. The contractor shall describe the method and criteria used to prioritize the problem list. The contractor should consider using scope of problem and resources available as criteria to prioritize the list. The list should be long while the MR strategy may only address the first few initially. When developing their prioritized list, the contractor shall consider their resources and other

operational areas of the contractor with similar goals. The MR strategy is a fluid document and shall be continuously reviewed and adjusted as problems are resolved and new problems take are addressed.

Quality Assurance:

The contractor shall list the data and the metrics used to determine and verify each identified problem. That is, each identified problem should have an explanation of data and other information used to support the decision to include the problem and assign its priority. In addition, the quality assurance process shall ensure that MR consults with POE to ensure that duplicate efforts are not being undertaken or consistently being overturned on appeal. Furthermore, an effective quality assurance process shall include periodic meetings with other operational areas, including POE.

1.2.3.5 - Budget and Workload Management

(Rev. 229, Issued: 11-23-07, Effective: 04-01-08, Implementation: 04-07-08)

In order to effectively determine appropriate budget levels and accurately predict workload, the contractor shall complete the following chart (omitting the shaded areas) for each strategy developed. Note that this chart is only for the purposes of developing an MR strategy. Contractors are expected to report workloads and costs associated with all CAFM II activity codes and assigned workloads. *PSCs and MACs* shall not report cost and workload using the CAFM II system. Instead, the PSC shall report cost and workload in the CMS ART system.

ACTIVITY CODE	ACTIVITY	BUDGET	PROJECTED WORKLOAD		
			Workload 1	Workload 2	Workload 3
MEDICAL REVIEW PROGRAM					
21001	Automated Review				
21002	Routine Reviews				
21007	Data Analysis				
21206	Policy Reconsideration/Revision				
21207	MR Program Management				
21208	New Policy Development				
21220	Complex Probe Sample Review				
21221	Prepay Complex Manual Review				
21221/01	Reporting for Advanced Determinations of Medicare Coverage (ADMC)				
21222	Postpay Complex Review				
21901	MIP CERT Support				

NOTE: When submitting the Interim Expenditure Report (IER), all defined workloads shall be entered.

In addition:

- The contractor shall explain methods for determining the appropriate amount of review for each CAFM II Activity Code. Contractors may perform automated, routine, and complex prepayment review and post-payment reviews. Contractors shall determine the appropriate amount of review to be performed for each CAFM II code within the constraints of their budget. Consideration shall be given to the cost effectiveness of each tool, as well as the appropriateness of each tool for resolving identified problems in achieving the overall goal of reducing the claims payment error rate.

– The contractor shall automate as much review as possible. For those types of review that cannot be automated, the contractor shall be able to justify why they cannot be automated. Only in those instances where reviews cannot be automated and does not require clinical judgment shall the contractor conduct routine reviews.

– The contractor shall identify any support services that will be provided to a PSC. The strategy shall detail the role of the PSC in the overall MR program for the contractor. For the PSCs that perform some medical review functions, they shall be involved with the development of the MR strategy.

- The contractor shall identify the process for determining when the contractor will develop or revise LCD.

1.2.3.6 - Staffing and Workforce Management

(Rev. 229, Issued: 11-23-07, Effective: 04-01-08, Implementation: 04-07-08)

Contractors shall complete and include the following chart to project the number of full-time-equivalent (FTE) employees, their job titles and qualifications.

CAFM II Code	FTE	Description & Qualifications
21001		
21002		
21007		
21010		
21206		
21207		
21208		
21220		
21221		
21221/01 (DMERCs only)		
21222		

The contractor shall submit a MR strategy each fiscal year *via the MR system located at CMS's Local Coverage Systems Portal Web site.* The MR strategy shall be updated as required. *MAC contractors shall submit a MR strategy within 30 days after contract award and thereafter 30 calendar days prior to option year award.*

7.8 – The Strategy Analysis Report (SAR)

(Rev. 229, Issued: 11-23-07, Effective: 04-01-08, Implementation: 04-07-08)

The problem-focused, outcome-based strategy (IOM 100-8, Chapter 1) provides a continuous feedback process that will assist the contractor with the management of their MR program. To assist in the feedback process, the contractor shall utilize a SAR. The PSC's *and MAC's* shall follow the SAR guidelines to the extent they can report on the elements they are responsible per their individual SOW. The goals of the SAR are to:

- Provide CMS with more specific information on how program funds are being used to reduce the claims payment error rate.
- Assist the contractor in performing analyses of the MR program and the allocation of resources.
- Assist the contractor in monitoring progress toward resolution of targeted problems.
- Improve the quality of information that will assist in the creation of outcome-based strategies.

The SAR shall address each problem identified in the strategy and the progress toward the projected outcomes. Monitoring the actions taken toward rectifying targeted problems will allow for early evaluation of the effectiveness of the interventions used. Close monitoring of the progress toward projected outcomes is crucial in alerting the contractor's MR management of when shifts in workload, targets, or resources will be needed. Shifts in the strategy are expected and should be identified in the SAR.

The contractor shall develop and submit a SAR that focuses on the progress made in the implementation of the contractor's MR strategy. The SAR will be problem-focused, and outcome-based, and will continually assess and evaluate the interventions being performed during the next 6 months to rectify the problems. The contractor shall also address quality assurance (QA) monitoring activities being performed in concurrence with the strategy and chosen interventions. QA activities shall include any follow-up activities performed to ensure resolution of problems addressed in the past.

In analyzing the activities for each problem, it may become evident that there needs to be a shift in workload or focus. Any shift in strategy should be identified in the SAR. If a shift in strategy impacting workload and/or dollars becomes evident, the contractor shall identify the specific activity line(s) impacted (increased or decreased) and provide the rationale for any redistribution of workload and funds amongst the activity lines and contractor sites in the SAR. Any shift of this nature impacting workload and/or costs would necessitate an MR strategy revision. In addition, the contractor shall provide an analysis of any site-specific variance between the fiscal year 2007 (FY 07) notice of budget approval (NOBA) and the reported quarterly cumulative Interim Expenditure Report (IER) workload and costs. Furthermore, the contractor shall provide explanations for variances as defined by the parameters in the following chart.

Required Variance Analysis Reporting for Medical Review (MR) Activity Codes
(use this as a guideline for Variance Analysis reporting only)

		Cost	Wrkld #1	Wrkld #2	Wrkld #3
21001	Automated Review	+/- 5%			
21002	Routine Manual Review	+/- 5%	+/- 10%		
21007	Data Analysis	+/- 5%			
21010	TPL	+/- 5%	+/- 10%		
21100	PSC Support Services	+/- 5%			
21206	Policy Reconsideration/Revision	+/- 5%	+/- 10%		
21207	MR Program Management	+/- 5%			
21208	New Policy Development	+/- 5%	+/- 10%		
21210	MR Reopenings	+/- 5%			
21220	Complex Manual Probe Review	+/- 5%	+/- 10%		
21221	Prepay Complex Review	+/- 5%	+/- 10%		
21222	Postpay Complex Review	+/- 5%	+/- 10%		

1) The contractor shall provide explanations for variances that fall outside of the above parameters
2) Please note that a variance analysis may not be required for NOBA/IER variance amounts < $5,000
3) Please note that the variance analysis should be site specific.
4) A copy of the variance analysis should be sent to the regional office.

This chart is included as a guideline to contractors for variance analysis reporting, and is not a required form to be completed or submitted with the SAR. The contractor shall include with the variance analysis any corrective actions that are planned or implemented. This process will allow the SAR to be the MR operations tool for analysis and reporting of variances by contractors, while the Variance Analysis Report (VAR) in CAFM II will be a contractor budget function. Contractor MR management shall review the budget VAR and add or expound upon the explanations provided their by budget staff. Since the PSC's *and MAC's* are not responsible for reporting their costs by CAFM code, they are not required to follow the CAFM II reporting and variance elements of the SAR. However, if there is a variation in workload that will effect the MR strategy at the

MAC, PSC, or the AC, the PSC shall be sure this is reflected in the SAR. The contractor shall submit the SAR by May 15 of each year *via the MR system located at CMS's Local Coverage Systems Portal Web site. MAC contractors shall submit the SAR 7 ½ months after contractor award or 7 ½ months after option is exercised.*