CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-08 Medicare Program Integrity	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 448	**Date: January 31, 2013**
	Change Request 8187

SUBJECT: Deletion of MR Operations mailbox

I. SUMMARY OF CHANGES: The purpose of this CR is to delete the instructions regarding sending conflict of interest issues to the MROperations@cms.hhs.gov mailbox.

EFFECTIVE DATE: March 4, 2013
IMPLEMENTATION DATE: March 4, 2013

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
R	1/1.4/Contractor Medical Director (CMD)

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; contractor's activities are to be carried out within their operating budgets.

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 obliged 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

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SUBJECT: Deletion of MR Operations mailbox

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I. GENERAL INFORMATION

A. Background: To prevent conflict of interest issues, the Contractor Medical Director (CMD) had to provide written notification to CMS as well as to the Carrier Advisory Committee (CAC), within 3 months after the appointment, election, or membership effective date if the CMD becomes a committee member or is appointed or elected as an officer in any State or national medical societies or other professional organizations. CMS no longer requires that this be reported to the MROperations@cms.hhs.gov mailbox.

B. Policy: CMS no longer requires that conflict of interest issues be reported to the MROperations@cms.hhs.gov mailbox.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
8187.1	CMDs shall no longer report conflict of interest issues to the MROperations@cms.hhs.gov mailbox.	X	X	X	X	X	X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility						
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Other
		Part A	Part B					
	None							

IV. SUPPORTING INFORMATION

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

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): Debbie Skinner, 410-786-7480 or debbie.skinner@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers:
No additional funding will be provided by CMS; contractor's 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 do 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.

1.4 - Contractor Medical Director (CMD)

(Rev.448 , Issued: 01-31-13, Effective:03-04-13 , Implementation: 03-04-13)

Contractors who perform medical review must employ a minimum of one FTE contractor medical director (CMD) and arrange for an alternate when the CMD is unavailable for extended periods. Waivers for very small contractors may be approved by the CO. The CMD FTE must be composed of either a Doctor of Medicine or a Doctor of Osteopathy. All clinicians employed or retained as consultants must be currently licensed to practice medicine in the United States, and the contractor must periodically verify that the license is current. When recruiting CMDs, contractors must give preference to physicians who have patient care experience and are actively involved in the practice of medicine. The CMD's duties are listed below.

Primary duties include:

- Leadership in the provider community, including:
    - Interacting with medical societies and peer groups;
    - Educating providers, individually or as a group, regarding identified problems or LCDs; and
    - Acting as co-chair of the carrier advisory committee (CAC) (see chapter 13 §13.8.1.4 of this manual for co-chair responsibilities).
- Providing the clinical expertise and judgment to develop LCDs and internal MR guidelines:
    - Serving as a readily available source of medical information to provide guidance in questionable claims review situations;
    - Determining when LCDs are needed or must be revised to address program abuse;
    - Assuring that LCDs and associated internal guidelines are appropriate;
    - Briefing and directing personnel on the correct application of policy during claim adjudication, including through written internal claim review guidelines;
    - Selecting consultants licensed in the pertinent fields of medicine for expert input into the development of LCDs and internal guidelines;
    - Keeping abreast of medical practice and technology changes that may result in improper billing or program abuse;
    - Providing the clinical expertise and judgment to effectively focus MR on areas of potential fraud and abuse; and
    - Serving as a readily available source of medical information to provide guidance in questionable situations.

Other duties include:

- Interacting with the CMDs at other contractors to share information on potential problem areas;
- Participating in CMD clinical workgroups, as appropriate; and
- Upon request, providing input to CO on national coverage and payment policy, including recommendations for relative value unit (RVU) assignments.