CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-08 Medicare Program Integrity	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 489	**Date: October 18, 2013**
	Change Request 8427

SUBJECT: 100% Prepayment Review and Random Review Instructions

I. SUMMARY OF CHANGES: This purpose of this CR is to provide instructions to the MACs on 100% Prepayment Review and Random Review.

EFFECTIVE DATE: November 19, 2013
IMPLEMENTATION DATE: November 19, 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	3/3.4/Prepayment Review of Claims

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

Pub. 100-08	Transmittal: 489	Date: October 18, 2013	Change Request: 8427

SUBJECT: 100% Prepayment Review and Random Review Instructions

EFFECTIVE DATE: November 19, 2013
IMPLEMENTATION DATE: November 19, 2013

I. GENERAL INFORMATION

A. Background: MACs have the discretion to conduct 100 % prepayment review of providers. CMS considers 100 % prepayment review to be appropriate when a provider has a prolonged time period of non-compliance.

MACs have the discretion to conduct random reviews of services; however, CMS does not recommend random reviews.

B. Policy: Section 1302 of the Health Care and Education Reconciliation Act (HCERA) repealed section 1874A (h) of the Social Security Act which had placed restrictions on prepayment medical review. CMS review contractors shall comply with Section C random review and Section D 100% prepayment review.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
8427.1	The MACs shall initiate targeted provider-specific prepayment review only when there is the likelihood of a sustained or high level of improper payments.	X	X	X	X	X	X	X					
8427.2	MACs shall notify the CMS Contracting Officer's Representative (COR), Regional Office Technical Monitor (TM), and Business Function Lead (BFL) of its intent to conduct random review.	X	X	X	X	X	X	X					
8427.3	The MAC shall describe what the intended result of the random review will be, an estimate of the number of claims to be reviewed randomly and the rationale as to why random review would be more effective than targeted review.	X	X	X	X	X	X	X					
8427.4	Any MAC that plans to conduct 100 % prepayment review shall inform the CMS COR, Regional Office TM, and BFL in advance about any provider being placed on 100 % prepayment	X	X	X	X	X	X	X					

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
	review.												
8427.5	The MAC shall provide 1. The background information on attempts to educate the provider. 1. The historical improper payment rate of the provider before beginning 100% prepayment review. 2. The length of time the provider is expected to be on 100 % prepayment reviews. 3. The estimated number of claims and the dollar value of claims expected to be reviewed per month. 4. The criteria for removing the provider from 100 % prepayment review.	X	X	X	X	X	X	X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility							
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Other
		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): 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.

3.4 - Prepayment Review of Claims

(Rev. 489, Issued: 10-18-13, Effective: 11-19-13, Implementation: 11-19-13)

This section applies to MACs.

A. General

Non-random (targeted) review is defined as review conducted with a specific reason or logic to substantiate the cause for review. MACs are encouraged to initiate non-random service-specific prepayment review to prevent improper payments for services identified by CERT or Recovery Auditors or other sources.
The MACs shall initiate targeted provider-specific prepayment review only when there is the likelihood of a sustained or high level of improper payments.

B. 100% Prepayment Review and Random Review Instructions

Section 1302 of the Health Care and Education Reconciliation Act (HCERA) repealed section 1874A (h) of the Social Security Act which had placed restrictions on prepayment medical review. CMS review contractors shall comply with Section 1 random review and Section 2 100% prepayment review.

1. Random Review

Random review is defined as review conducted without a specific reason or logic to substantiate the cause for review. MACs have the discretion to conduct random reviews of services; however, CMS does not recommend random reviews. MACs shall notify the CMS Contracting Officer's Representative (COR), Regional Office Technical Monitor (TM), and Business Function Lead (BFL) of its intent to conduct random review. The MAC shall describe what the intended result of the random review will be, an estimate of the number of claims to be reviewed randomly and the rationale as to why random review would be more effective than targeted review.

2. 100% Prepayment Review

100% prepayment review is defined as review of every claim submitted by a targeted provider for a specific code (i.e. DRG, CPT, HCPCs). 100% prepayment review also includes review of every claim submitted by the targeted provider.
MACs have the discretion to conduct 100 % prepayment review of providers. CMS considers 100 % prepayment review to be appropriate when a provider has a prolonged time period of non-compliance with CMS policies. Any MAC that plans to conduct 100 % prepayment review shall inform the CMS COR, Regional Office TM, and BFL in advance about any provider being placed on 100 % prepayment review. In addition, the MAC shall provide

- *The background information on attempts to educate the provider.*
- *The historical improper payment rate of the provider before beginning 100% prepayment review.*
- *The length of time the provider is expected to be on 100 % prepayment reviews.*
- *The estimated number of claims and the dollar value of claims expected to be reviewed per month.*
- *The criteria for removing the provider from 100 % prepayment review.*