CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 540	**Date: September 4, 2014**
	Change Request 8802

Transmittal 534, dated August 8, 2014, is being rescinded and replaced by Transmittal 540, dated September 4, 2014, to adhere to CMS Inpatient recoding policy standards, which was accomplished by removing the recoding language in section 3.2.3 in the Manual Instructions. All other information remains the same.

SUBJECT: Claims that are Related

I. SUMMARY OF CHANGES: The purpose of this CR is to allow the MACs and ZPICs the discretion to deny claims that are "related" and provide approved examples of such situations.

EFFECTIVE DATE: September 8, 2014
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: September 8, 2014

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	3/3.2.3/Requesting Additional Documentation During Prepayment and Postpayment Review

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 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

Attachment - Business Requirements

Pub. 100-08	Transmittal: 540	Date: September 4, 2014	Change Request: 8802

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SUBJECT: Claims that are Related

EFFECTIVE DATE: September 8, 2014
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IMPLEMENTATION DATE: September 8, 2014

I. GENERAL INFORMATION

A. Background: The purpose of this CR is to allow the MAC and ZPIC to have the discretion to deny other "related" claims submitted before or after the claim in question. If documentation associated with one claim can be used to validate another claim, those claims may be considered "related."

B. Policy: The purpose of this CR is to allow the MAC and ZPIC to have the discretion to deny other "related" claims submitted before or after the claim in question. If documentation associated with one claim can be used to validate another claim, those claims may be considered "related."

The MAC and ZPIC shall await CMS approval prior to initiating requested "related" claim(s) review. Approved examples of "related" claims that may be denied as "related" are in the following situations:

- The MAC performs post-payment review/recoupment of the admitting physician's and /or surgeon's Part B services. For services related to inpatient admissions that are denied because they are not appropriate for Part A payment (i.e., services could have been provided as outpatient or observation), the MAC reviews the hospital record and if the physician service was reasonable and necessary the service will be recoded to the appropriate outpatient evaluation and management service. 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 will occur for the performing physician's Part B service.

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	
8802.1	The MAC and ZPIC shall have the discretion to deny other "related" claims submitted before or after the claim in question, subject to CMS approval.	X	X	X	X					ZPICs

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
8802.2	The MAC and ZPIC shall await CMS approval prior to initiating requested “related” claim(s) review.	X	X	X	X					ZPICs
8802.2.1	The MAC shall post the intent to conduct “related” claim review(s) to their Web site within 1 month of initiation, upon CMS approval.	X	X	X	X					
8802.2.2	The MAC shall inform CMS of the implementation date of the “related” claim review 1 month prior to the implementation date.	X	X	X	X					
8802.3	The MACs shall count "related" claims that are denied automatically as automated review.	X	X	X	X					
8802.3.1	The MACs shall count "related" claims that are denied after manual intervention routine review.	X	X	X	X					
8802.4	The Recovery Auditor shall utilize the review approval process as outlined in their SOW when performing reviews of “related” claims.									RA
8802.5	The MAC, Recovery Auditor, and ZPIC shall not be required to request additional documentation for the “related” claims before issuing a denial for the “related” claims.	X	X	X	X					RA, ZPICs
8802.6	Contactors shall process appeals of the “related” claim(s) separately.	X	X	X	X					

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): Jennifer McCormick, 410-786-2852 or Jennifer.McCormick1@cms.hhs.gov

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

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

3.2.3 - Requesting Additional Documentation During Prepayment and Postpayment Review

(Rev.540, Issued: 09-04-14, Effective: 09-08-14, Implementation: 09-08-14)

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

A. General

In certain circumstances, the MACs, CERT, Recovery Auditors, and ZPICs 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, Recovery Auditors, and ZPICs 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, Recovery Auditor, and ZPIC 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 subreview mitted 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 ZPIC 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 ZPIC 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 of 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 routine review.

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

The MAC, Recovery Auditor, and ZPIC 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 is 0938-0969. This number shall be on every additional documentation request or any other type of written request for additional documentation for medical review. It can be in the header, footer or body of the document. CMS suggest the information read "OMB #: 0938-0969" or OMB Control #: 0938-0969."

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 seven calendar "waiting" days (from the date of receipt) for additional the unsolicited documentation to be faxed or ten 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 seven/ten will be discussed with and approved by your contracting officer prior to implementation. When the documentation is received, the contractor has 60 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 PIM. These procedures include: sending an ADR request to the provider, allowing 45 days for receipt of documentation, making a determination within 60 days of receipt the last piece of documentation.