| CMS Manual System | Department of Health & Human Services (DHHS) |
|---|---|
| Pub 100-08 Medicare Program Integrity | Centers for Medicare & Medicaid Services (CMS) |
| **Transmittal 568** | **Date: February 4, 2015** |
| | **Change Request 8443** |

**Transmittal 566, dated January 23, 2015, is being rescinded and replaced by Transmittal 568 to correct the transmittal number, which was inadvertently duplicated for CR 8443. Additionally, information from CR 8802, section 3.2.3 that was erroneously overwritten has been included. All other information remains the same.**

**SUBJECT: Review Timeliness Requirements for Prepay Review**

**I. SUMMARY OF CHANGES:** The purpose of this change request (CR) is to change the number of days MACs have to conduct complex review from 60 days to 30 days.

**EFFECTIVE DATE: March 1, 2015**
**The effective date is based on the claim receipt date.*
**IMPLEMENTATION DATE: March 1, 2015**

***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 |
| **R** | 3/3.3.1.1/Complex Medical 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: 568 | Date: February 4, 2015 | Change Request: 8443 |
|---|---|---|---|

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**SUBJECT: Review Timeliness Requirements for Prepay Review**

**EFFECTIVE DATE: March 1, 2015**
**The effective date is based on the claim receipt date.*
**IMPLEMENTATION DATE: March 1, 2015**

## I. GENERAL INFORMATION

**A. Background:** CMS currently allows 60 days for contractors to make complex review determinations after the documentation has been received.

**B. Policy:** This CR changes the number of days MACs have to conduct complex review from 60 days to 30 days.

## 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 | |
| 8443.1 | Recovery Auditors and Supplemental Medical Review Contractor(s) shall ensure that the credentials of their reviewers are consistent with the requirements in their respective SOWs. | | | | | | | | | RACs, SMRC |
| 8443.2 | Recovery Auditors and the Supplemental Medical Review Contractor(s) shall follow guidance related to calling upon other healthcare professionals as outlined in their respective SOWs. | | | | | | | | | RACs, SMRC |
| 8443.3 | Contractors shall establish a Quality Improvement (QI) process that verifies the accuracy of MR decisions made by licensed health care professionals. | X | X | X | X | | | | | CERT, RACs, SMRC |
| 8443.4 | Contractors shall attend the annual medical review | X | X | X | X | | | | | CERT, RACs, |

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| | training conference as directed by the CMS and/or their SOW. | | | | | | | | | SMRC |
| 8443.5 | Contractors shall include inter-rater reliability assessments in their QI process and shall report these results as directed by CMS. | X | X | X | X | | | | | CERT, RACs, SMRC |
| 8443.6 | Contractors shall request as part of the ADR, during a complex medical record review, a copy of any mandatory ABNs, as defined in IOM 100-04, Medicare Claims Processing Manual Chapter 30 section 50.3.1. | X | X | X | X | | | | | CERT, RACs, SMRC, ZPICs |
| 8443.7 | When a MAC receives requested documentation for ***prepayment*** review within 45 calendar days of the date of the ADR, the MAC shall do the following within *30* calendar days of receiving the requested documentation: 1) make and document the review determination, 2) enter the decision into the Fiscal Intermediary Shared System (FISS), Multi-Carrier System (MCS), or the VIPS Medicare System (VMS). | X | X | X | X | | | | | |
| 8443.7.1 | The MACs shall make and enter a review determination for Third Party Liability claims within 60 calendar days. | X | X | X | | | | | | |
| 8443.7.2 | The 30 calendar day timeframe shall apply to prepayment routine reviews, prepayment complex reviews and prepayment documentation compliance reviews. | X | X | X | X | | | | | |
| 8443.8 | When a Recovery Auditor receives requested documents for a postpayment review within 45 calendar days, they shall make and document the review determination and communicate the results to the provider within 30 days. | | | | | | | | | RACs |
| 8443.9 | The MACs and Recovery Auditors shall count day one as the date each new medical record is received in the mailroom. The MACs and Recovery Auditors shall give each new medical record received an independent 30 day review time period. | X | X | X | X | | | | | RACs, SMRC |

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| 8443.10 | MACs shall adhere to state laws that require an evidentiary hearing for the beneficiary before any denials are processed. | X | X | X | X | | | | | |
| 8443.10.1 | MACs shall review the claim within 30 days, allow the time required for the evidentiary hearing, and then continue with the processing of the claim on the next business day. | X | X | X | X | | | | | |
| 8443.11 | MACs shall use the appropriate OMB control number on every additional documentation request or any other type of written request for additional documentation for prepayment medical review. | X | X | X | X | | | | | |
| 8443.12 | MACs shall adjust their medical review strategy and medical review workloads as necessary to accommodate this change request as no additional funding will be provided. | X | X | X | X | | | | | |
| 8443.12.1 | MACs shall describe any necessary workload changes in detail, including the rationale for these changes to their COR and medical review BFL. | 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):** Marissa Malcolm, 410-786-0119 or Marissa.Malcolm@cms.hhs.gov , 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 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. 568, Issued: 02-04-15, Effective: 03-01-15, Implementation: 03-01-15)*

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 submitted 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 prior to 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 *for prepayment medical review* is 0938-0969. *MACs shall use this number* on every additional documentation request or any other type of written request for additional documentation for *prepayment* medical review. It can be in the header, footer or body of the document. CMS suggests the information read "OMB #: 0938-0969" or OMB Control #: 0938-0969." *Postpayment medical review does not require an OMB control number.*

**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 7 calendar "waiting days" (from the date of receipt *of the claim*) for additional unsolicited documentation to be *submitted* or 10 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 7/10 *days* will be discussed with and approved by your contracting officer prior to implementation. When the documentation is received, the contractor has *30 calendar* 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 Program Integrity Manual.

## 3.3.1.1 - Complex Medical Review

***(Rev. 568, Issued: 02-04-15, Effective: 03-01-15, Implementation: 03-01-15)***

This section applies to MACs, CERT, Recovery Auditors, Supplemental Medical Review Contractor*(s)* and ZPICs, as indicated.

## A. Credentials of Reviewers

The MACs, CERT, and ZPICs shall ensure that complex reviews for the purpose of making coverage determinations are performed by licensed nurses (RNs and LPNs) or physicians, unless this task is delegated to other licensed health care professionals. Recovery Auditors *and the Supplemental Medical Review Contractor(s)* shall ensure that the credentials of their reviewers are consistent with the requirements *in their respective* SOW*s*.

During a complex review, nurse and physician reviewers may call upon other health care professionals (e.g., dieticians or physician specialists) for advice. The MACs, CERT, and ZPICs shall ensure that services reviewed by other licensed health care professionals are within their scope of practice and that their MR strategy supports the need for their specialized expertise in the adjudication of particular claim type (i.e., speech therapy claim, physical therapy). Recovery Auditors *and the Supplemental Medical Review Contractor(s)* shall follow guidance related to calling upon other healthcare professionals as outlined in *their respective* SOW*s*.

Recovery Auditors shall ensure that complex reviews for the purpose of making coding determinations are performed by certified coders. *CERT* and MACs are encouraged to make coding determinations by using certified coders. ZPICs have the discretion to make coding determinations using certified coders.

## B. Credential Files

The MACs, CERT, Recovery Auditors, and ZPICs shall maintain a credentials file for each reviewer (including consultants, contract staff, subcontractors, and temporary staff) who performs complex reviews. The credentials file shall contain at least a copy of the reviewer's active professional license.

## C. Quality Improvement (QI) Process

The MACs, CERT, Recovery Auditors, *and Supplemental Medical Review Contractor(s)* shall establish a Quality Improvement (QI) process that verifies the accuracy of MR decisions made by licensed health care professionals. The MACs, CERT, Recovery Auditors, *and Supplemental Medical Review Contractor(s)* shall attend the annual medical review training conference as directed by the CMS *and/or their SOW*. The MACs, CERT, Recovery Auditors*, and Supplemental Medical Review Contractor(s)* shall include inter-rater reliability assessments in their QI process and shall report these results as directed by CMS.

## D. Advanced Beneficiary Notice (ABN)

The MACs, CERT, Recovery Auditors, ZPICs, *and Supplemental Medical Review Contractor(s)* shall request as part of the ADR, during a complex medical record review, a copy of any mandatory ABNs, as defined in Pub. 100-04, Medicare Claims Processing Manual Chapter 30 section 50.3.1. If the claim is determined not to be reasonable and necessary, the contractor will perform a face validity assessment of the ABN in accordance with the instructions stated in Pub. 100-04 Medicare Claims Processing Manual chapter 30 section 50.6.3.

The Face Validity assessments do not include contacting beneficiaries or providers to ensure the accuracy or authenticity of the information. Face Validity assessments will assist in ensuring that liability is assigned in accordance with the Limitations of Liability Provisions of section 1879 of the Social Security Act.

## E. MAC Funding Issues

The MAC complex medical review work performed by medical review staff for purposes other than MR (e.g., appeals) shall be charged, for expenditure reporting purposes, to the area requiring medical review services.

All complex review work performed by MACs shall:

- Involve activities defined under the Medicare Integrity Program (MIP) at Section 1893(b)(1) of the Act;

- Be articulated in its medical review strategy; and,

- Be designed in such a way as to reduce its Comprehensive Error Rate Testing (CERT) error rate or prevent the contractor's error rate from increasing.

The MACs shall be mindful that edits suspending a claim for manual review to check for issues other than inappropriate billing (i.e. completeness of claims, conditions of participation, quality of care) are not medical review edits as defined under Section 1893(b)(1) of the Act and cannot be funded by MIP. Therefore, edits resulting in work other than that defined in Section1893 (b) (1) shall be charged to the appropriate Program Management activity cost center.

**F. Review Timeliness Requirements**

*Prepayment Review Requirements for MACs*

When a MAC receives requested documentation for *prepayment* review within 45 calendar days *of the date of the ADR*, the MAC shall do the following within *30* calendar days of receiving the requested documentation: 1) make and document the review determination *and* 2) enter the decision into the Fiscal Intermediary Shared System (FISS), Multi-Carrier System (MCS), or the VIPS Medicare System (VMS). *The 30 calendar day timeframe applies to prepayment routine reviews, prepayment complex reviews and prepayment documentation compliance reviews. The 30 calendar day timeframe does not apply to prepayment reviews of Third Party Liability claims. The MACs shall make and enter a review determination for Third Party Liability claims within 60 calendar days.*

Postpayment Review *Requirements for MACs*

The MAC shall make a review determination, and mail the review results notification letter to the provider within 60 calendar days of receiving the requested documentation, provided the documentation is received within 45 calendar days of the date of the ADR.

*Postpayment Review Requirements for Recovery Auditors*

*When a Recovery Auditor receives requested documentation for review within 45 calendar days of the date of the ADR, the Recovery Auditor shall do the following within 30 calendar days of receiving the requested documentation: 1) make and document the review determination, and 2) communicate the results to the provider.*

*Counting the 30 Calendar Day Timeframe*

*The MACs and Recovery Auditors shall count day one as the date each new medical record is received in the mailroom. The MACs and Recovery Auditors shall give each new medical record received an independent 30 day review time period.*

*Prepayment Review Requirements for ZPICs*

When a ZPIC receives all documentation requested for prepayment review within 45 calendar days *of the date of the ADR*, the ZPIC shall make and document the review determination and notify the MAC of its determination within 60 calendar days of receiving all requested documentation.

*State Laws that Affect Prepayment Review Timeliness Requirements*

*The MACs shall adhere to state laws that require an evidentiary hearing for the beneficiary before any denials are processed. The MAC shall review the claim within 30 days, allow the time required for the evidentiary hearing, and then continue with the processing of the claim on the next business day.*

**G. Auto Denial of Claim Line Item(s) Submitted with a GZ Modifier**

Effective for dates of service on and after July 1, 2011, all MACs, PSCs and ZPICs shall automatically deny claim line(s) items submitted with a GZ modifier. Contractors shall not perform complex medical review on claim line(s) items submitted with the GZ modifier. The GZ modifier indicates that an ABN was not issued to the beneficiary and signifies that the provider expects denial due to a lack of medical necessity based on an informed knowledge of Medicare policy. All MACs shall make all language published in educational outreach materials, articles, and on their Web sites, consistent to state all claim line(s) items submitted with a GZ modifier shall be denied automatically and will not be subject to complex medical review. See Pub. 100-04, Medicare Claims Processing Manual, chapter 23, section 20.9.1.1. under paragraph F "GZ Modifier" for codes and the MSN to be used when automatically denying claim line(s) items submitted with a GZ modifier.