CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-08 Medicare Program Integrity	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 634	**Date: January 22, 2016**
	Change Request 9333

SUBJECT: Reviewers' Credentials, Notifying the Provider, CARC Code Update

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to instruct the Medicare Administrative Contractors (MACs) that they shall maintain a record of their medical reviewers' credentials and provide them to providers upon request and also include them in the Appeal administrative files. The Centers for Medicare & Medicaid Services' (CMS) Center for Program Integrity (CPI) has added an additional requirement to the post payment review results letter.

EFFECTIVE DATE: April 22, 2016 - The Effective Date is the Process Date
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 22, 2016

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	3/3.6.4/Notifying the Provider

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 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

Attachment - Business Requirements

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I. GENERAL INFORMATION

A. Background: The purpose of this CR is to instruct the MACs to provide the credentials of their medical review staff to a provider if they should request it. This would only apply to the medical review staff that conducted the review of the claim or prior authorization request that the provider is requesting. Only the reviewers' credentials shall be provided. The reviewers' credentials shall also be included in all Appeals administrative files. Also, CMS' CPI has added an additional requirement to the post payment review results letter.

B. Policy: There are no regulatory, legislative, or statutory requirements related to this CR.

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	
9333.1	Contractors shall include in the review results letter the following statement notifying the provider that a revocation of billing privileges should occur if issues identified in the review continue: "Per 42 C.F.R. §424.535(a)(8)(ii), CMS has the authority to revoke a currently enrolled provider or supplier's Medicare billing privileges and any corresponding provider agreement based on a pattern or practice of submitting claims that fail to meet Medicare requirements. Should you continue to fail to meet these requirements as described in this letter, your billing privileges may be revoked on this basis or any of the bases articulated in 42 C.F.R. §424.535(a);"	X	X	X	X					ZPICs
9333.2	Contractors shall maintain and provide documentation upon a provider's request listing the credentials of the individuals making the medical review determinations.	X	X	X	X					SMRC, ZPICs
9333.3	The contractors shall include reviewers' credentials in all Appeals administrative files.	X	X	X	X					SMRC, ZPICs

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
9333.4	The contractors shall issue a denial and indicate in the provider denial notice, using Group Code: CO – Contractual Obligation and Claim Adjustment Reason Code (CARC): 50 these are non-covered services because this is not deemed a "medical necessity" by the payer for claims where the MAC, SMRC or ZPIC had sent an ADR letter and no timely response was received.	X	X	X	X					SMRC, ZPICs
9333.5	The contractor should indicate in the denial notice, using Group Code: CO – Contractual Obligation and Claim Adjustment Reason Code (CARC): 50 these are non-covered services because this is not deemed a "medical necessity" by the payer for claims where the reviewer makes a denial following complex review.	X	X	X	X					SMRC, ZPICs

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:
	The following statement notifying the provider that a revocation of billing privileges should occur if issues identified in the review continue: "Per 42 C.F.R. §424.535(a)(8)(ii), CMS has the authority to revoke a currently enrolled provider or supplier's Medicare billing privileges and any corresponding provider agreement based on a pattern or practice of submitting claims that fail to meet Medicare requirements. Should you continue to fail to meet these requirements as described in this letter, your billing privileges may be revoked on this basis or any of the bases articulated in 42 C.F.R. §424.535(a)." This statement should be included on the postpayment review results letter as applicable.

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).

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

The Reviewer 3.6.4 - Notifying the Provider

(Rev. 634, Issued: 01-22-16, Effective: 04-22-16, Implementation: 04-22-16)

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

A. General

At the conclusion of postpayment review, the MACs shall send a Review Results Letter to the provider even if no overpayment determination is made. If the MACs choose to send a Review Results Letter separately from the demand letter they shall do so within the timeframes listed in PIM chapter 3, §3.3.1.1F. Likewise, the Recovery Auditors shall issue a Review Results Letter for complex audits as outlined in their SOW requirements. ZPICs shall comply with the requirements listed below when issuing Review Results Letters.

Each Review Results Letter shall include:

- Identification of the provider or supplier—name, address, and NPI;
- Reason for conducting the review or good cause for reopening;
- A narrative description of the overpayment situation that states the specific issues involved in the overpayment as well as any recommended corrective actions;
- The review determination for each claim in the sample, including a specific explanation of why any services were determined to be non-covered, or incorrectly coded and if others were payable;
- A list of all individual claims that includes the actual non-covered amount, the reason for non-coverage, the denied amounts, under/overpayment amounts, the §1879 and §1870 of the Act determinations made for each specific claim, along with the amounts that will and will not be recovered from the provider or supplier;
- *The following statement notifying the provider that a revocation of billing privileges should occur if issues identified in the review continue: "Per 42 C.F.R. §424.535(a)(8)(ii), CMS has the authority to revoke a currently enrolled provider or supplier's Medicare billing privileges and any corresponding provider agreement based on a pattern or practice of submitting claims that fail to meet Medicare requirements. Should you continue to fail to meet these requirements as described in this letter, your billing privileges may be revoked on this basis or any of the bases articulated in 42 C.F.R. §424.535(a);"*
- Any information required by PIM chapter 8, §8.4 for statistical sampling for overpayment estimation reviews;
- Total underpayment amounts;
- Total overpayment amounts that the provider or supplier is responsible for;
- Total overpayment amounts the provider or supplier is not responsible for because the provider or supplier was found to be without fault;
- MACs shall include an explanation that subsequent adjustments may be made at cost settlement to reflect final settled costs;
- An explanation of the procedures for recovery of overpayments including Medicare's right to recover overpayments and charge interest on debts not repaid within 30 days (not applicable to Recovery Auditors or ZPICs);

- The provider's or supplier's right to request an extended repayment schedule (not applicable to Recovery Auditors or ZPICs);

- The MACs and ZPICs shall include limitation of liability and appeals information in the provider notices;

- The MACs shall include appeals information in the provider notices;

- The MACs shall include the provider or supplier financial rebuttal rights under PIM chapter 3, §3.6.5; and,

- For MAC Review Results Letter only, a description of any additional corrective actions or follow-up activity the MAC is planning (i.e., prepayment review, re-review in 6 months).

If a claim is denied through prepayment review, the MACs and ZPICs are encouraged to issue a notification letter to the provider but may use a remittance notice to meet this requirement. However, if a claim is denied through postpayment review, the MAC and Recovery Auditor shall notify the provider by issuing a notification letter to meet this requirement. The ZPIC shall use discretion on whether to issue a notification letter.

The CERT contractor is NOT required to issue provider notices for claims they deny. Instead, the CERT contractor shall communicate sufficient information to the MAC to allow the MAC to develop an appropriate provider notice.

For prepayment and postpayment reviews, the MACs, SMRC, and ZPICs shall maintain and provide documentation upon a provider's request listing the credentials of the individuals making the medical review determinations. This only includes the reviewer's credentials. The reviewer's credentials shall also be included in all Appeals administrative files. The MACs, SMRC, and ZPICs are not required to share names and personal information with the provider.

B. MACs

The MACs need provide only high-level information to providers when informing them of a prepayment denial via a remittance advice. In other words, the shared system remittance advice messages are sufficient notices to the provider. However, for complex review, the provider should be notified through the shared system, but the MAC shall retain more detailed information in an accessible location so that upon written or verbal request from the provider, the MAC can explain the specific reason the claim was denied as incorrectly coded or otherwise inappropriate.

C. Recovery Auditors

For overpayments detected through **complex** review, the Recovery Auditor shall send a review results letter as indicated in the Recovery Auditor SOW. In addition, the Recovery Auditor shall communicate sufficient information to the MAC so that the MAC can send a remittance advice to the provider and collect the overpayment.

For overpayments detected through **non-complex** review, the Recovery Auditor shall notify the provider as indicated in the Recovery auditor SOW and will communicate sufficient information to the MAC so that the MAC can send a Remittance Advice to the provider.

For underpayments, the Recovery Auditor shall notify the provider as indicated in the Recovery Auditor SOW. In addition, the Recovery Auditor shall communicate sufficient information to the MAC so that the MAC can send Remittance Advice to the provider and pay back the underpayment.

D. ZPICs

For overpayments detected through **complex** review, and after coordination between the ZPIC and OIG, the ZPIC shall send a review results letter (the MAC sends the demand letter). In addition, the ZPIC shall communicate sufficient information to the MAC so that the MAC can send a demand letter to the provider and collect the overpayment. The ZPIC shall use discretion on whether to send the review results letter.

E. Indicate in the Denial Notice Whether Records Were Reviewed

For claims where the MAC, *SMRC* or ZPIC had sent an ADR letter and no timely response was received, they shall issue a denial and indicate in the provider denial notice, using *Group Code: CO – Contractual Obligation and Claim Adjustment Reason Code (CARC): 50 these are non-covered services because this is not deemed a "medical necessity" by the payer*. This information will be useful to the provider in deciding whether to appeal the decision.

For claims where the reviewer makes a denial following complex review, the reviewer has the discretion to indicate in the denial notice, using *Group Code: CO – Contractual Obligation and Claim Adjustment Reason Code (CARC): 50 these are non-covered services because this is not deemed a "medical necessity" by the payer*. This includes those claims where the provider submits documentation along with the claim and the reviewer selects that claim for review.