CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-06 Medicare Financial Management	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 210	**Date: May 18, 2012**
	Change Request 7733

SUBJECT: Validation of Recovery Audit Program New Issues

I. SUMMARY OF CHANGES: The MAC/Contractors will participate in the validation of new issues presented for Recovery Auditor review. This validation review is for automated, semi-automated, and non-medical necessity complex coding reviews.

EFFECTIVE DATE: June 19, 2012
IMPLEMENTATION DATE: June 19, 2012
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	4/100/Table of Contents
N	4/100.17/Validation of Recovery Audit Program New Issues

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
Funding for implementation activities will be provided to contractors through the regular budget process.

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
**Unless otherwise specified, the effective date is the date of service.*

Attachment – Business Requirements

Pub. 100-06	Transmittal: 210	Date: May 18, 2012	Change Request: 7733

SUBJECT: Validation of Recovery Audit Program New Issues

Effective Date: June 19, 2012
Implementation Date: June 19, 2012

I. GENERAL INFORMATION:

A. Background: The MAC/Contractor will participate in the validation of new issues presented for Recovery Auditor review. This validation review is for automated, semi-automated, and complex reviews.

B. Policy: Section 302 of the Tax Relief Act and Health Care Act of 2006.

II. BUSINESS REQUIREMENTS TABLE:

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7733.1	The MAC/Contractor shall develop a process to receive new issue packages in order to complete a validation review.	X	X	X	X	X					
7733.2	The MAC/Contractor shall perform all necessary testing to ensure new issue package file transfers, to/from Recovery Auditors, are successful.	X	X	X	X	X					
7733.3	The MAC/Contractor shall establish a Point of Contact (POC) responsible for coordinating the validation reviews and serving as the POC for CMS questions. There can either be a single POC, or two separate POCs, one for Part A and one for Part B.	X	X	X	X	X					
7733.4	The MAC/Contractor shall review all documents within each new issue packet along with the submitted sample claims related to that package. Package documents may include the proposal form, CMS policy reference document(s), sample Good Cause language, edit parameters, review guidelines, code lists, and other relevant documents.	X	X	X	X	X					
7733.5	The MAC/Contractor shall review all claim samples for each new issue package. The maximum number of sample claims per new issue package is 10.	X	X	X	X	X					

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7733.6	The MAC/Contractor shall submit to CMS a written Validation Report, for each new issue package reviewed. The format of the Validation Report will be supplied by CMS.	X	X	X	X	X					
7733.7	The MAC/Contractor shall submit each Validation Report to CMS via email to the designated CMS POC.	X	X	X	X	X					
7733.8	The MAC/Contractor shall include, in each Validation Report, detailed rationale for why each review element (listed below) of a new issue proposal package is, or is not, correct. 1. Appropriate Medicare policy(s) cited for Jurisdiction of review 2. Beneficiary liability assessed correctly 3. Appropriate error code assigned 4. Review type (automated, semi-automated, complex) is appropriate 5. Edit parameters are appropriate to correctly identify improper payments, as described in the New Issue name/description 6. Sample claims represent true improper payments under this audit concept 7. Recovery Auditor's review rationale is correct, for each sample claim 8. Recovery Auditor's review name, description and good cause language are appropriate	X	X	X	X	X					
7733.9	The MAC/Contractor shall include, in each Validation Report, a recommendation(s) to correct any review elements found to be incorrect.	X	X	X	X	X					
7733.10	The MAC/Contractor shall submit each Validation Report to CMS within 25 calendar days of the MAC/Contractor receiving the package.	X	X	X	X	X					
7733.11	The MAC/Contractor shall participate in conference calls with CMS and/or the Recovery Auditor on ad hoc basis when needed to settle disputes or to answer questions related to the proposed audit	X	X	X	X	X					
7733.12	The MAC/Contractor shall develop a Quality Assurance process to ensure the accuracy of the Validation Report.	X	X	X	X	X					
7733.13	When implementing system edits based on edit parameters from New Issue Proposals, the MAC/Contractor shall not run previously paid claims against these edits, without prior authorization from CMS.	X	X	X	X	X					

III. PROVIDER EDUCATION TABLE:

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	None.										

IV. SUPPORTING INFORMATION:

Section A: For any recommendations and supporting information associated with listed requirements, use the box below: N/A

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS:

Pre-Implementation Contact(s): LCDR Brian Elza, 410-786-7456, brian.elza@cms.hhs.gov; or, CAPT Marie Casey, 410-786-7861, marie.casey@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), Carriers, and Regional Home Health Intermediaries (RHHIs)*:

Funding for implementation activities will be provided to contractors through the regular budget process.

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 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

Medicare Financial Management
Chapter 4 - Debt Collection

Table of Contents
(Rev.210, Issued: 05-18-12)

Transmittals Issued for this Chapter

100.17 – Validation of Recovery Audit Program New Issues

100.17 - Validation of Recovery Audit Program New Issues (Rev.210, Issued: 05-18-12, Effective: 06-19-12, Implementation: 06-19-12)

The Recovery Auditor shall forward all new issue packages to the MAC/Contractor for review. The MAC/Contractor shall develop a process to receive new issue packages in order to complete a validation review. The MAC/Contractor shall perform all necessary testing to ensure new issue package file transfers, to/from Recovery Auditors, are successful. The MAC/Contractor shall establish a point of contact (POC) responsible for coordinating the validation reviews and serving as the POC for CMS questions. There can either be a single POC, or two separate POCs, one for Part A and one for Part B.

The MAC/Contractor shall review all documents within each new issue packet along with all the submitted sample claims (maximum of 10) related to that package. Package documents may include the proposal form (Exhibit 1 below), CMS policy reference document(s), relevant evidenced-based medical literature to support the review, sample Good Cause language, edit parameters, review guidelines, code lists, review results letter language, and other relevant documents.

Upon completion of the package review, the MAC/Contractor shall send a written Validation Report (Exhibit 2 below) to CMS. The written report shall summarize the MAC/Contractor's opinion of whether CMS should approve the new issue for widespread review. See Section 100.19 for an exhibit of the Validation report.

Each Validation Report shall include detailed rationale for why each review element (listed below) of a new issue proposal package is, or is not, correct.

- *Appropriate Medicare policy(s) cited for Jurisdiction of review and/or other evidence-based medical literature*
- *Beneficiary liability assessed correctly*
- *Appropriate error code assigned*
- *Review type (automated, semi-automated, complex) is appropriate*
- *Edit parameters are appropriate to correctly identify improper payments, as described in the New Issue name/description*
- *Sample claims represent true improper payments under this audit concept*
- *Recovery Auditor's review rationale is correct, for each sample claim*
- *Recovery Auditor's review name, description and good cause language are appropriate.*

The MAC/Contractor shall include in each Validation Report recommendation(s) on how to correct any review element(s) found to be inaccurate. The MAC/Contractor shall submit each Validation Report to CMS within 25 calendar days of the MAC/Contractor receiving the package.

The MAC/Contractor shall submit each Validation Report to CMS via email to the designated CMS POC until submission through the eRAC system is possible. Once available, the MAC/Contractor shall perform all necessary testing to implement submission of Validation Reports through the eRAC system. CMS will send notification of when testing is to begin.

The MAC/Contractor shall participate in conference calls with CMS and/or the Recovery Auditor on ad hoc basis when needed to settle disputes or to answer questions related to the proposed audit. The MAC/Contractor shall develop a Quality Assurance process to ensure the accuracy of the Validation Report.

When implementing system edits based on edit parameters from New Issue Proposals, the MAC/Contractor shall not run previously paid claims against these edits, without prior authorization from CMS .

Note: The Validation Report is a recommendation to CMS regarding approval of the issue. CMS will determine whether the issue will be approved for review.

Exhibit 1: New Issue Proposal Form template

APPENDIX A RAC New Issue Proposal Form		
1	Name of RAC:	
2	POC Name:	
3	Date Submitted:	
4	Issue Name:	
5	Issue Description	
6	Affected Code (s) and Code Descriptor(s):	
7	Overpayment or Underpayment:	
8	Automated, Semi-automated, or Complex Review:	
9	Who is liable?	
10	Single or Multiple Providers:	
11	Error Code:	
12	Provider Type:	
13	Reference(s) (Statute, Regulation, Ruling, Manual, etc) and timeframe reference is applicable:	
14	Detailed explanation of reference and why improper payment exists (you may attach your review results/demand letter)	
15	Specific State(s) in which	

	reference is applicable:		
16	Specific State(s) in which you are planning to perform review		
17	Link to rule/reference (if no URL is available, please send a copy on CD)		
18	Date of Service for each claim in sample:		
19	Improper payment amount per claim:		
20	Number of claims in error per State/Region:		
21	Total potential dollar error in State/Region for RAC Universe:	Per State:	Per Region:
22	Total number of records/claims identified to have the error in the sample	Per State:	Per Region:
23	Is this a Referral? Yes/No		Referring Entity:
24	Alphanumeric Issue Number (Assigned by CMS)		
25	Please check to indicate that you have included the following:		
	Copy of Reference(s) (Statute, Regulation, Ruling, Manual, etc):		
	Good Cause Language (you may attach your demand letter for automated reviews or review results letter for complex reviews)		
	Detailed Review Rationale for each claim (you may attach your demand letter for automated reviews or review results letter for complex reviews)		
	Medical Records (if applicable)		
	Sample of claims		
	Edit parameters (for		

	automated review) or review guidelines (for complex reviews)	
	Other/additional documentation	
26	Any additional information:	

Exhibit 2: Validation Report template

Validation Contractor New Issue Review Summary		
MAC/contractor Name:		
Contract Jurisdiction:		
Recovery Auditor Name:		
Report Date:		
Issue # and Name:		
Issue Description:		
Review Type: (automated, semi-automated, or complex)		
Review Elements	**Validation Contractor Agreement (yes/no)**	**Brief Comments**
Appropriate Medicare policy(s) is cited to support review		
Beneficiary Liability is assessed correctly		
Error Code is appropriate		

<table>
<tr><td>Review type (Automated/Semi-Automated/Complex) is appropriate</td><td></td><td></td></tr>
<tr><td>Edit Parameters are appropriate</td><td></td><td></td></tr>
<tr><td>Sample claims represent true improper payments</td><td></td><td></td></tr>
<tr><td>Review rationale is correct, for each sample claim</td><td></td><td></td></tr>
<tr><td>Improper payment amount is calculated correctly, for each sample claim</td><td></td><td></td></tr>
<tr><td>Review name, description, and good cause language are appropriate</td><td></td><td></td></tr>
<tr><td colspan="3"></td></tr>
<tr><td rowspan="5">Overall Validation Rationale (Detailed Comments)</td><td colspan="2">Initial Validation Review (Date & Reviewer Name & Credential)</td></tr>
<tr><td colspan="2">Analysis/Regulation Analysis:</td></tr>
<tr><td colspan="2">Claim Analysis :</td></tr>
<tr><td colspan="2">Additional References:</td></tr>
<tr><td colspan="2">Recommendation:</td></tr>
</table>

	2nd or 3rd Level Reviewer Analysis (if applicable)
	QA Review (10% Random Sample) Date/QA Reviewer's Name & Credential)