Medicare Program Integrity Manual
Chapter 7 - MR Reports

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(Rev. 10365, 10-02-20)

Transmittals for Chapter 7

7.1 - Annual Improper Payment Reduction Strategy (IPRS)
(Rev. 599, Issued: 06-26-15, Effective: 12-07-15, Implementation: 12-07-15)

7.1.1 - General Overview
(Rev. 599, Issued: 06-26-15, Effective: 12-07-15, Implementation: 12-07-15)

The annual Improper Payment Reduction Strategy (IPRS) is a problem-focused, outcome-based operational plan developed by the Medicare Administrative Contractor (MAC) that identifies risks to the Medicare Trust Fund and describes the improper payment interventions to be implemented to ensure proper payments and address the risks. The IPRS addresses both provider and service-specific vulnerabilities and includes a prioritization of the problems based on data analysis findings and the availability of resources.

Specifically, the IPRS details:

- Identified medical review (MR) prioritized problems
- Data analysis for each prioritized problem
- All MR activities, provider outreach & education (POE), and other improper payment interventions focused on the prioritized problems
- Measureable and achievable improvement goals for each prioritized problem
- Evaluation methodology for the planned goals and improper payment interventions
- Quality assurance activities
- Workload and staffing detail
- Program management information

7.1.2 - IPRS Required Format
(Rev. 599, Issued: 06-26-15, Effective: 12-07-15, Implementation: 12-07-15)

All elements listed below shall be addressed by the MAC in the IPRS. Each of these requirements is described in detail in the following sections:

- Cover Page
- Overview/Executive Summary
- Data Analysis and Information Gathering Plan
- Prioritized Problem List
- MR Activities and Improper Payment Interventions Planning
- Program Management
- Quality Assurance Plan

7.1.2.1 - Cover Page
(Rev. 599, Issued: 06-26-15, Effective: 12-07-15, Implementation: 12-07-15)

The cover page shall include the following information:

- MAC name and address
- MAC contract number
- States in jurisdiction
- Period of performance (an explanation shall be included if the IPRS is reporting on a period of performance less than 12 months)
- Report coordinator contact information (name, telephone number and e-mail address)
- IPRS due date and submission date

7.1.2.2 - Overview/Executive Summary
(Rev. 599, Issued: 06-26-15, Effective: 12-07-15, Implementation: 12-07-15)

The MAC shall provide a high level summary of their planned MR activities, improper payment interventions, and quality assurance activities for their upcoming period of performance.

7.1.2.3 - Data Analysis and Information Gathering Plan
(Rev. 599, Issued: 06-26-15, Effective: 12-07-15, Implementation: 12-07-15)

The MAC shall target their efforts on those services, items, and providers/suppliers in their jurisdiction that pose the greatest financial risk to the Medicare Trust Fund and that represent the best investment of resources to reduce the national improper payment rate (IPR).

The first step in creating or updating an IPRS is to establish a priority-setting process to assure MR activities and other interventions are focused on areas with the greatest potential for improper payments. The MACs shall analyze and gather data from a variety of sources for this purpose. The MACs' Comprehensive Error Rate Testing (CERT) findings shall be used as a primary source of data. However, CERT findings are only one indication of where to focus and shall not be relied upon as the single source of data information. The MAC shall consult a variety of resources. Examples of other appropriate resources include, but are not limited to:

- Recovery Auditor-identified problem
- Comparative billing reports (CBRs)
- Office of Inspector General (OIG) or Government Accountability Office (GAO) reports
- MAC data analysis on a specific benefit, diagnostic/procedure code, or place of service. This analysis shall include an identification of the specific cause of improper payments
- Evaluation of utilization or probes

The MAC shall provide detailed information of the data analysis conducted for purposes of developing the IPRS. The data analysis plan shall list the data resources used in developing the prioritized problem list. If a prioritized problem is carried over from a previous IPRS or Strategy Analysis Report (SAR) the MAC shall provide information

regarding the current, updated data analysis conducted to ensure that the prioritization of the problem is accurate and current. If a former prioritized problem is not carried over from a previous IPRS or SAR, an explanation and data shall also be provided.

7.1.2.4 - Prioritized Problem List
(Rev. 599, Issued: 06-26-15, Effective: 12-07-15, Implementation: 12-07-15)

The MAC shall develop a prioritized problem list after data analysis has been completed. The MAC shall list five to ten prioritized problems, for each appropriate claim type (Durable Medical Equipment, Prosthetics, Orthotics, & Supplies (DMEPOS), Part A, Part B, and Home Health and Hospice (HHH)), selected for inclusion in the IPRS.

The MAC shall describe the method, criteria, and data analysis used to prioritize the problem list. The MAC shall consider their resources and other operational areas of the MAC with similar goals when developing the prioritized problem list.

The prioritized problem list shall include the identified payment errors/vulnerabilities that can be addressed through MR activities, POE, and other improper payment interventions. The MR problems for the current contract year, as well as problems that are carried over from the previous IPRS or SAR, shall be included. Any prioritized problems carried over from a previous IPRS or SAR shall include an explanation. The MAC shall also include a rationale if top errors identified by CERT are not included in the prioritized problem list. Top errors would be the top service/claim types by projected improper payments within the MAC's jurisdiction and nationally.

The following requirements shall be included for each specific prioritized problem:

- **Whether the prioritized problem is a new or a carry-over problem.**

- **Data source/analysis that led to the identification of the problem**. The IPRS shall identify the source of data that led to the identification of the problem for inclusion in the IPRS.

- **MAC-specific improper payment rate as measured by the CERT program and/or the MAC.** This information shall demonstrate how this problem contributes to the MAC and national improper payment rates. The MAC shall specify whether the improper payment rate was measured by the CERT program or the MAC.

- **Cause(s) of the problem.** The IPRS shall identify the specific cause of the error/vulnerability resulting in improper payments. Such causes may include, but are not limited to, insufficient clinical documentation, incorrect coding, unnecessary utilization, inadequate provider understanding of relevant CMS rules, lack of medical necessity, or the rendering of services in the incorrect clinical setting.

- **Baseline measurement to be used for the purpose of assessing improvement.** The IPRS shall identify the baseline measurement that will be used for the purpose of assessing improvement through time. This section shall also describe the process for calculating the starting/baseline problem measurement (e.g., IPR, claims denial rate, charges denial rate, provider error rate). An assessment of progress towards accomplishment of the improvement goals cannot be made unless the starting point/baseline problem measurement is known. For example, an improvement goal to reduce the problem measurement or to improve provider compliance with coverage requirements by a specific percentage without the baseline or starting problem measurement does not enable measurement of progress towards the improvement goal.

- **Achievable and measureable improvement goals.** The IPRS shall include concrete improvement goals for each prioritized problem that are data-driven, achievable, and measurable. The establishment of improvement goals will require the MAC to use information from the MAC MR, data analysis, POE, and other departments, as appropriate. CMS does not mandate the MAC to use any specific improvement goal; however, selected improvement goals and MR activities and improper payment interventions shall ultimately contribute to lowering the overall improper payment rate and/or to an improvement in provider billing behavior. The outcome shall be the reduction of the starting/baseline problem measurement as listed in the specific improvement goal (e.g. improvement of provider billing/provider error rate; number of providers removed from review due to decrease in their error rate, reduction of error rate etc.). Specifically, this section shall include:

  o The timeframe to achieve the improvement goal.

  o An explanation of progress or lack of progress towards accomplishment of the improvement goal (when the improvement goal is carried over from the previous IPRS or SAR).

  o Parameters or thresholds for removing a provider/supplier from MR activities or other interventions as it relates to the improvement goal.

  o Evaluation methods that test the effectiveness and efficiency of MR activities and other improper payment reduction interventions.

7.1.2.4.1 – Carried-Over Prioritized Problems
(Rev. 599, Issued: 06-26-15, Effective: 12-07-15, Implementation: 12-07-15)

In addition to the requirements listed above, the MAC shall address the following elements for problems that are carried over from previous contract year's IPRS or SAR to the current contract year's IPRS. These sections shall include problem-specific discrete figures and measurements:

- **The effectiveness or ineffectiveness of the MR, POE, and other improper payment interventions in reducing the baseline problem measurements.** The MAC shall document the progress made towards achieving the goal, or an explanation of why the goal was partially met or not met within the specified timeframe. If there is lack of progress towards accomplishment of an improvement goal, the MAC shall clearly document the obstacles contributing to the lack of progress towards accomplishment of an improvement goal. The MAC shall also offer rationale for either not taking the next steps in progressive corrective action or for continuing current interventions. A continuous lack of progress towards goal completion and failure to provide a justification for the lack of progress will be considered unacceptable and require revisions to the IPRS.

- **Whether modification to the plan is required.** A modified plan, if appropriate, shall be developed by the MAC to remedy the obstacles that inhibited progress towards accomplishment of the improvement goals. This section shall describe how the MAC is revising or modifying the goals and/or the MR, POE, and other improper payment interventions, as appropriate.

No previous prioritized problems may be omitted from the current IPRS without an explanation. CMS must be able to track progress on all prioritized problems and their goals from a previous IPRS. When previous prioritized problems improve or meet their goals, or when priorities shift to other problem areas, the MAC may inactivate the previous prioritized problem or set new improvement goals for that problem.

7.1.2.5 - MR Activities and Improper Payment Interventions Planning
(Rev. 10365; Issued: 10-02-20; Effective: 08-27-20; Implementation: 08-27-20)

For each prioritized problem, the MAC shall develop a comprehensive plan of MR activities and other improper payment interventions using the Progressive Corrective Action (PCA) process. The MAC shall develop multiple tools to effectively address identified problems. The scope and severity of the identified problems shall determine the MR activities and improper payment interventions needed to successfully address the problems.

The MR activities and improper payment interventions shall be tailored to the nature of the problem. Existing interventions that have proven effective in reducing improper payments shall be used as one basis for the implementing of MR activities and other improper payment interventions. The effectiveness of existing MR activities and other improper payment interventions shall be explained in discrete figures and/or improper payment rates.

The MAC shall include an estimated date of implementation for each planned MR activity and improper payment intervention.

The MR activities and improper payment interventions may include, but are not limited to:

- MR Activities
- Provider or service-specific probes
- Targeted medical reviews (TMRs)
- Notification letters
- POE priority referrals
- Automated denials based on local coverage determinations (LCDs)
- Edit modifications
- Post-payment and statically valid random sampling (SVRS) extrapolation
- Development or revisions of LCDs
- Probe review education
- POE activities
- Recalcitrant provider process

The MAC shall describe the process for provider selection for MR activities and other improper payment interventions. For example, the MAC may describe review criteria in the following manner: "Providers whose denied claims represent over x percent of the dollar amount reviewed will be placed on a prepay review or providers who have a provider error rate > x percent will be placed on an x percent prepay review."

If initial MR activities and improper payment interventions are insufficient to improve the provider's billing behavior, a priority referral to POE for potential intervention may be necessary. A POE priority referral indicates to the POE department that this is a problem which MR has determined will likely require further educational intervention.

Through communication with POE, it is determined that MR activities, improper payment interventions and POE educational efforts have not effectively resolved the problem, a referral to the *Unified Program Integrity Contractors (UPIC)*, Recovery Auditor or the recalcitrant process may be indicated.

If an improper payment intervention is to refer the provider to another entity, i.e., Recovery Auditor, *UPIC*, or Quality Improvement Organization (QIO), the MAC shall have backup MR activities or improper payment interventions if the referral is not accepted by the other entity.

The MR department shall employ an effective follow-up process that ensures appropriate resolution of the issue. If provider billing aberrances continue, the MAC shall use information obtained via consultation with other areas of the MAC which shall include the POE department to develop a revised comprehensive plan of MR activities and other improper payment interventions using the PCA process. This plan may involve increases in MR prepay review or conducting Statistical Sampling for Overpayment Estimation (SSOE). As issues are successfully resolved, the MAC shall continue to address other program errors/vulnerabilities identified on the prioritized problem list.

The MAC MR department shall have a system to track all referrals to POE, medical review activities, and improper payment interventions used to address identified problems. The MAC MR shall work with POE to develop an effective tracking system for referred problems. The Contractor shall track all contacts made by their MR unit with providers, *UPICs*, and Recovery Auditors during the course of medical review.

7.1.2.5.1 - Contractor Suggestions
(Rev. 599, Issued: 06-26-15, Effective: 12-07-15, Implementation: 12-07-15)

Contractors shall report suggestions on how CMS can help reduce the national improper payment rate (e.g., may include national efforts, policy changes, or other broad strategies).

7.1.2.6 - Program Management
(Rev. 599, Issued: 06-26-15, Effective: 12-07-15, Implementation: 12-07-15)

Program management encompasses managerial responsibilities inherent in managing the MR program, including: development, modification, and reporting of strategies and quality assurance activities; planning, monitoring, and adjusting workload performance; budget-related monitoring and reporting; and implementation of CMS MR changes/instructions.

7.1.2.6.1 - Budget and Workload Management
(Rev. 599, Issued: 06-26-15, Effective: 12-07-15, Implementation: 12-07-15)

The IPRS shall include a section that describes the process used to monitor budget and workload for the MR activities definitions. The process shall ensure that spending is consistent with the allocated budget and include procedures to revise or amend the plan when spending is over or under the budget allocation. The MAC shall have a table in the IPRS identifying the MR workload for the current period of performance.

The MAC shall assess the cost effectiveness of each MR activity and appropriateness of each MR activity. The MAC shall determine if the resources required for the planned MR activity can contribute to achieving the reduction of the improper payment error rate. In addition, the IPRS shall describe how workload for each MR activity is accurately and consistently reported. The workload reporting process shall also assure the proper allocation of employee hours required for each MR activity.

7.1.2.6.1.1 – Workload Reporting Tables
(Rev. 721; Issued: 06-09-17; Effective: 07-11-17; Implementation: 07-11-17)

The following tables shall be included in the IPRS:

Medical Review Program Workload A/B MAC and HHH MAC

Statement of Work (SOW)	MR Activity	Part A Projected Workload for this Period of Performance	Part B Projected Workload for this Period of Performance	Home Health Projected Workload for this Period of Performance	Hospice Projected Workload for this Period of Performance
C.5.12.1.6	Defending MR Decisions at ALJ Hearings				
C.5.12.2.1	Automated Medical Review				
C.5.12.2.2	Non-Medical Record Review				
C.5.12.2.3	Demand Bill Claims Review				
C.5.12.2.4	Medical Record Review Reopening				
C.5.12.2.5	Prepay Provider Specific Medical Record Review				
C.5.12.2.6	Prepay Service Specific Medical Record Review				
C.5.12.2.7	Prepay Probe Provider Specific Medical Record Review				
C.5.12.2.8	Prepay Probe Service Specific Medical Record Review				
C.5.12.2.10	Postpay Probe Provider Specific Medical Record Review				
C.5.12.2.11	Postpay Probe Service Specific Medical Record Review				
C.5.12.2.12	Postpay Provider Specific Medical Record Review				

Statement of Work (SOW)	MR Activity	Part A Projected Workload for this Period of Performance	Part B Projected Workload for this Period of Performance	Home Health Projected Workload for this Period of Performance	Hospice Projected Workload for this Period of Performance
C.5.12.2.13	Postpay Service Specific Medical Record Review				
C.5.12.2.17	Externally Directed Reviews				
C.5.12.2.18	Provider compliance Group Directed Reviews				
C.5.12.2.20	One on One Education				

Medical Review Program Workload DME MAC

SOW	MR Activity	Projected workload for this Period of Performance
4.7.1	Automated Medical Review	
4.7.2	Non-Medical Record Review	
4.7.3	Demand Bill Claims Review	
4.7.4	Medical Record Review Reopening	
4.7.5	Prepay Provider Specific Medical Record Review	
4.7.6	Prepay Service Specific Medical Record Review	
4.7.7	Prepay Probe Provider Specific Medical Record Review	
4.7.8	Prepay Probe Service Specific Medical Record Review	
4.7.10	Postpay Probe Provider Specific Medical Record Review	
4.7.11	Postpay Probe Service Specific Medical Record Review	
4.7.12	Postpay Provider Specific Medical Record Review	
4.7.13	Postpay Service Specific Medical Record Review	
4.7.17	Externally Directed Reviews	
4.7.18	Provider Compliance Group Directed Reviews	
4.7.22	One on One Education	
4.12	Defending MR decisions at ALJ Hearings	

7.1.2.6.2 - Staffing and Workload Management
(Rev. 599, Issued: 06-26-15, Effective: 12-07-15, Implementation: 12-07-15)

The MACs shall list the number, job titles, and qualifications/credentials of all full-time-equivalent (FTE) employees. If resources allow, an MR Nurse may be shared with another functional area, such as claims processing, so long as only the percentage of the nurses time spent on MR activities is identified in the strategy and accounted for in the appropriate functional area. For example, if MR agrees to share 0.5 of an FTE with claims processing to assist with the pricing of Not Otherwise Coded claims, this 0.5 FTE shall be accounted for in claims processing and not in MR.

7.1.2.7 - Quality Assurance (QA) Plan
(Rev. 599, Issued: 06-26-15, Effective: 12-07-15, Implementation: 12-07-15)

In each element of the IPRS, the MAC shall incorporate quality assurance (QA) activities. The QA activities ensure that each element is performed consistently and accurately throughout the MAC's MR program. The MAC shall have in place continuous quality improvement procedures. Quality improvement procedures use information yielded from quality assurance methods and allow the MAC to analyze the outcomes from their program and to continually improve the effectiveness of their processes.

The QA process shall include effective consultations between MR, POE, and other components, as appropriate, to ensure that duplicate efforts are not being undertaken. The QA process shall inform the MAC if claims subject to MR activity are consistently overturned on appeal. An effective QA process shall include regular meetings with other operational areas, including data analysis, policy development, POE, and appeals.

Because the MAC is tasked with evaluating their MR program activities, it is necessary to establish QA activities that include thresholds and time limits for the MAC to assess their MR operations that ultimately improve the IPR. Examples include, but are not limited to:

- Data analysis
- Educational interventions
- Inter-Rater Reliability (IRR) for MR licensed health care professionals and certified coders participating in medical review
  - Define acceptable IRR rates and actions taken for not meeting those acceptable rates
- Accuracy of medical review decisions
  - Define acceptable accuracy rates and actions taken for not meeting those acceptable rates
- Overturn rate on appeals
- Cost of review
- Edit effectiveness

7.1.2.7.1 - QA for Data Analysis and Information Gathering
(Rev. 599, Issued: 06-26-15, Effective: 12-07-15, Implementation: 12-07-15)

The MAC shall develop a QA process for data analysis and information gathering that frequently reviews the data and how the information is used.

The MAC shall:

- Establish an internal process for routinely reviewing data results
- Document the job titles, qualifications and contract operational areas represented by those who routinely review the data results
- Describe the log tracking system(s) utilized for data analysis and how this information was developed by the MAC
- Describe how decisions are made as a result of the data analysis meetings.

7.1.2.7.2 - QA for Development of the Prioritized Problem List
(Rev. 599, Issued: 06-26-15, Effective: 12-07-15, Implementation: 12-07-15)

The MAC shall list the data and the metrics used to determine and verify each identified prioritized problem. That is, each identified prioritized problem shall have an explanation of current data and other information used to support the decisions to include the problem and assign its priority. The QA process shall ensure that MR activities and improper payment interventions are not dedicated to problems that are consistently overturned on appeal, based on outdated data analysis, or the focus of other operational areas of the MAC with similar goals.

The QA shall be performed for each intervention that checks for effectiveness and progress towards the specified goal. The QA component shall include a projected goal, a timeline to achieve the goal, and an element to assess effectiveness of the intervention and progress towards the stated goal. The QA component shall include a determination of whether the problem has been resolved or partially met, or whether a more progressive course of action is required. The MAC shall evaluate the effectiveness of edits and the priority status of the problem. An effective QA process shall also include periodic meetings with other operational areas, such as POE.

7.1.2.7.3 - QA for Program Management
(Rev. 599, Issued: 06-26-15, Effective: 12-07-15, Implementation: 12-07-15)

The MAC shall describe the processes employed to assure accuracy and consistency in the reporting of spending, workload, and staffing levels. The MAC shall address how to maintain accuracy in medical review decision-making and IRR assessments and shall report the results of the IRR for the MR licensed health care professionals and certified coders participating in the medical review process. Each IPRS, SAR shall contain the IRR scores for the period of performance covered by that reporting period.

7.1.3 - IPRS Submission

(Rev. 599, Issued: 06-26-15, Effective: 12-07-15, Implementation: 12-07-15)

The MAC shall submit an IPRS as directed by the SOW and Contracting Officer's Representative (COR). The current IPRS shall be updated or revised as required by the COR after review by the Business Function Leads (BFLs) (MR, CERT and POE) and the Regional Office (RO) Technical Monitor (TM) MR staff.

7.1.4 - IPRS Revision
(Rev. 599, Issued: 06-26-15, Effective: 12-07-15, Implementation: 12-07-15)

The MAC shall notify their COR, RO TM and the MR BFL when their IPRS requires a revision/update of the final approved IPRS. Any revisions/updates shall be described in the medical review section of the current monthly status report. The IPRS revision shall be included in the next strategy deliverable (either the IPRS or SAR).

7.2 - Medical Review Activity Definitions
(Rev. 444, Issued: 12-14-12, Effective: 04- 01- 13 (FISS and MCS); 07-01-13 (VMS); Implementation: April 1, 2013 (Implementation of FISS and MCS); July 1, 2013 (Implementation of VMS)

7.2.1 - Background
(Rev. 444, Issued: 12-14-12, Effective: 04- 01- 13 (FISS and MCS); 07-01-13 (VMS); Implementation: April 1, 2013 (Implementation of FISS and MCS); July 1, 2013 (Implementation of VMS)

This section provides requirements and instructions for Part A, Part B, and Durable Medical Equipment (DME) MACs, fiscal intermediaries (FIs), and carriers.

The reporting requirements for Medical Review (MR) activities performed by the Contractor were formerly captured in the Program Integrity Management Reporting (PIMR) system. Effective 7/1/2012, the PIMR system was retired, requiring the revision to this chapter of the Program Integrity Manual.

The new process for the oversight of Medical Review activities administered by the Contractor will improve the management of medical review cost, savings, and workload. The manual Medical Review Savings reporting process will replace the Program Integrity Manual Review system.

The Medical Review, savings, and workload data shall be collected through the use of a manual report until such a time that it is decided that an automated reporting system is required and developed to meet the business needs of The CMS Office of Financial Management, Provider Compliance Group, Division of Medical Review and Education. The CMS will obtain Medical Review Savings data through manual reporting by Contractor staff. Those reports will be due monthly, on the20th day of the month.

7.2.2 – Definitions

(Rev. 721; Issued: 06-09-17; Effective: 07-11-17; Implementation: 07-11-17)

The reporting process will require data that can be classified under three different categories of activity measures: Workload, Cost, and Savings. The Medical Review definitions shall apply to all Medical Review activities and shall not be deviated from or interpreted differently than stated below. The consistency in the application of these definitions will provide validity to the data reported that is required to assess the effectiveness of the CMS Medical Review and Education Program being administered by the Contractor(s)

MEDICAL REVIEW

The review of claims and associated medical documentation that occurs when review staff:

1. Make a coverage decision (benefit category, statutory exclusion, or reasonable and necessary) and a coding decision to determine the appropriate payment for claims, or

2. Investigate complaints to determine whether a corrective action was effective (e.g., an MR activity such as provider notification letter), or identify situations that require prepayment edits or the development of a local coverage determination (LCD).

The medical review process requires the application of clinical judgment either as part of a review, in writing policies, or in the development of guidelines and processing instructions. For local medical review edits, input must be from the Contractor Medical Review clinicians/staff. For national edits, input from the Contractor medical/clinical staff is not necessary. The medical review can be performed either before or after the claim has been paid. Generally, a line cannot result in medical review workload or savings if it is not referred to medical review. A line that potentially involves both medical review and claims processing work should suspend to a claims processing reviewer, and that reviewer should refer the line to medical review only if the claims processing reviewer cannot make a decision based on guidelines available to that reviewer.

Do NOT consider the review as medical review if it requires:

1. Pricing Only, or
2. Coding Only, or
3. Pricing and Coding only.

Consider the review as medical review if:

1. Pricing is based on medical record review determination. or
2. Coding is based on medical record review determination, or

3. Coding and Pricing are based on medical record review determination.

If an automated claims processing edit has already made a decision to pay, and the claim only suspends for pricing, consider the review automated claims processing and do not count it for medical review workload or costs.

7.2.2.1 - Automated Medical Review
(Rev. 721; Issued: 06-09-17; Effective: 07-11-17; Implementation: 07-11-17)

A medical review is considered automated when a payment decision is made at the system level, using available electronic information, with no manual intervention. It must be based on guidelines for which the contractor's Medical Review area has developed some or all of the logic for review of specific billing and coverage criteria based on vulnerabilities identified by the Contractor's Medical Review area. This process is done completely through the Medical Review Contractors' technology developed in response to medical review data analysis.

7.2.2.2 - Non-Medical Record Review
(Rev. 721; Issued: 06-09-17; Effective: 07-11-17; Implementation: 07-11-17)

Non-medical record reviews uses manual intervention, but only to the extent a reviewer can make a determination based on information on a claim. It does not require clinical judgment in review of medical record documentation. Contractors shall only perform a non-medical record review for denials of related claims and/or no receipt of ADR documentation where such denials cannot be automated.

7.2.2.3 - Demand Bill Claims Review
(Rev. 444, Issued: 12-14-12, Effective: 04- 01- 13 (FISS and MCS); 07-01-13 (VMS); Implementation: April 1, 2013 (Implementation of FISS and MCS); July 1, 2013 (Implementation of VMS)

Demand bills are submitted at the beneficiary's/representative's request because the beneficiary disputes the provider's opinion that the bill will not be paid by Medicare and requests the bill be submitted for a payment determination. The demand bill is identified by the presence of a condition code 20. There must be a written request from the beneficiary to submit the bill, unless the beneficiary is deceased or incapable of signing. In this case, the beneficiary's guardian, relative or other authorized representative may make the request. This includes SNF and HHA demand bills as well as other demand bills (outpatient) and Third Party Liability Medical Reviews.

7.2.2.4 - Medical Review Reopening
(Rev. 444, Issued: 12-14-12, Effective: 04- 01- 13 (FISS and MCS); 07-01-13 (VMS); Implementation: April 1, 2013 (Implementation of FISS and MCS); July 1, 2013 (Implementation of VMS)

A MR reopening is a remedial action taken to review and change a final determination or decision that resulted in either an overpayment or an underpayment, even though the determination for decision was correct based on the evidence in the record. It is separate and distinct from the appeals process. The Contractor may choose to reopen a claim for late documentation. The MR department shall conduct a reopening of claims sent by the appeals department which meet the criteria in IOM Pub. 100-04, Section 10.3. (1) A provider failed to timely submit documentation through an Additional Documentation Request (ADR) (2) Claim was denied because the requested documentation was not received timely (3) the requested documentation is received after the 45 day period with or without a request for redetermination or reopening AND (4) The request is filed within 120 days of the receipt of the initial determination. Do not count more than one reopening per claim.

7.2.2.5 - Prepay Provider Specific Medical Record Review
(Rev. 721; Issued: 06-09-17; Effective: 07-11-17; Implementation: 07-11-17)

Medical record review requires a licensed medical professional to use clinical review judgment to evaluate medical records. This includes requests for, collection and evaluation of medical records or any other documentation. The review is as a result of vulnerabilities determined by data analysis and identified in the Medical Review strategy. If the requested documentation is not received, the review is not considered medical record review. The failure of the provider to submit documentation shall result in a denial. Contractors shall use 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 and Remittance Advice Remark Code (RARC) M127 - Missing patient medical record for this service. For the purpose of calculating and reporting MR workload, cost and savings, contractors shall count these denials as automated reviews or non-medical record reviews depending on the method of development.

7.2.2.6 - Prepay Service Specific Medical Record Review
(Rev. 721; Issued: 06-09-17; Effective: 07-11-17; Implementation: 07-11-17)

Medical record review requires a licensed medical professional to use clinical review judgment to evaluate medical records. Service specific prepay medical review of claims requires that a medical review determination be made before claim payment directed at a certain service. It includes requests for, collection and evaluation of medical records or any other documentation. The review is as a result of vulnerabilities determined by data analysis and identified in the Medical Review strategy. The failure of the provider to submit documentation shall result in a denial. Contractors shall use 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 and Remittance Advice Remark Code (RARC) M127 - Missing patient medical record for this service. For the purpose of calculating and reporting MR workload, cost and savings, contractors shall count these denials as automated review or non-medical record review depending on whether the denial is automated or requires manual intervention.

7.2.2.7 - Prepay Provider Specific Probe Medical Record Review
(Rev. 10365; Issued: 10-02-20; Effective: 08-27-20; Implementation: 08-27-20)

Medical record review requires a licensed medical professional to use clinical review judgment to evaluate medical records. Prepay probe medical record reviews are done to verify that the program vulnerability identified through data analysis actually exists and will require education and possible targeted medical record review. In the case of a possible provider specific problem, contractors should generally use a sample of 20 -40 claims submitted by that individual provider.

The Contractor shall validate data analysis findings by conducting probe reviews and implementing the necessary PCAs in accordance with IOM Pub.100-08 Chapter 3. Once a problem has been verified, the Contractor shall implement the necessary PCA. This includes providing the initial notification informing the provider of the results of the probe review, and collaborating with Provider Outreach and Education (POE) to share potential educational needs, and making referrals to POE, *UPICs*, RACs, or others as appropriate.

7.2.2.8 - Prepay Service Specific Probe Medical Record Review
(Rev. 10365; Issued: 10-02-20; Effective: 08-27-20; Implementation: 08-27-20)

Medical record review requires a licensed medical professional to use clinical review judgment to evaluate medical records. Prepay service specific probe medical record reviews are done to verify that the program vulnerability identified through data analysis actually exists and will require education and possible targeted medical review. For Prepay review in the case of a possible systemic problem, the contractor shall include a random or stratified sample of generally 100 claims submitted from across all providers or suppliers that bill the particular item or service in question.

The Contractor shall validate data analysis findings by conducting probe reviews and implementing the necessary PCAs in accordance with IOM Pub.100-08 Chapter 3. Once a problem has been verified, the Contractor shall implement the necessary PCA. This includes providing the initial notification of the results of the probe review, and collaborating with Provider Outreach and Education (POE) to share potential educational needs, and making referrals to POE, *UPICs*, RACs or others as appropriate.

7.2.2.9 - Advance Determination Medicare Coverage (ADMC)
(Rev. 444, Issued: 12-14-12, Effective: 04- 01- 13 (FISS and MCS); 07-01-13 (VMS); Implementation: April 1, 2013 (Implementation of FISS and MCS); July 1, 2013 (Implementation of VMS)

At the request of a supplier or beneficiary, the DME MAC may determine in advance of delivery of an item whether payment for that item is medically necessary. The request must contain adequate information from the patient's medical record to identify the

patient for whom the item is intended, the intended use of the item, and the medical condition of the patient that necessitates the use of the item.

7.2.2.10 - Postpay Provider Specific Probe Medical Record Review
(Rev. 10365; Issued: 10-02-20; Effective: 08-27-20; Implementation: 08-27-20)

Medical record review requires a licensed medical professional to use clinical review judgment to evaluate medical records. Postpay provider specific probe medical record reviews are done to verify that the program vulnerabilities identified through data analysis actually exist and will require education and/or further medical review. For postpay review of an individual provider in the case of a possible provider specific problem, contractors shall include in the probe sample a random or stratified sample of generally 20 -40 claims from that provider with dates of service from the period under review.

The Contractor shall validate data analysis findings by conducting probe reviews and implementing the necessary PCAs in accordance with, IOM Pub. 100-08 Chapter 3. Once a problem has been verified, the Contractor shall implement the necessary PCA. This includes providing the initial notification informing the provider of the results of the probe review, and collaborating with Provider Outreach and Education (POE) to share potential educational needs, and making referrals to POE, *UPICs*, RACs or others as appropriate.

7.2.2.11 - Postpay Service Specific Probe Medical Record Review
(Rev. 10365; Issued: 10-02-20; Effective: 08-27-20; Implementation: 08-27-20)

Medical record review requires a licensed medical professional to use clinical review judgment to evaluate medical records. Postpay service specific probe medical record reviews are done to verify that the program vulnerabilities identified through data analysis actually exist and will require education and/or further medical review. For Postpay review in the case of a possible service/systemic problem, the contractor should generally include a random or stratified sample of 100 claims with dates of service from the period under review from across all providers or suppliers that bill the particular item or service in question.

The Contractor shall validate data analysis findings by conducting probe reviews and implementing the necessary PCAs in accordance with, IOM Pub. 100-08 Chapter 3. Once a problem has been verified, the Contractor shall implement the necessary PCA. This includes providing the initial notification of the results of the probe review, and collaborating with Provider Outreach and Education (POE) to share potential educational needs, and making referrals to POE, *UPICs*, RACs or others as appropriate.

7.2.2.12 - Postpay Provider Specific Medical Record Review
(Rev. 721, Issued: 06-09-17; Effective: 07-11-17; Implementation: 07-11-17)

Medical record review requires a licensed medical professional to use clinical review judgment to evaluate medical records. Provider specific postpay medical record review of claims requires that a benefit category review, statutory exclusion review, and/or reasonable and necessary review be made after claim payment directed at an individual provider. This includes requests for, collection and evaluation of medical records or any other documentation. The review is as a result of vulnerabilities determined by data analysis and identified in the Medical Review strategy. The failure of the provider to submit documentation shall result in a denial. Contractors shall use 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 and Remittance Advice Remark Code (RARC) M127 - Missing patient medical record for this service. For the purpose of calculating and reporting MR workload, cost and savings, this is postpay medical record review and is not to be counted as a probe review.

7.2.2.13 - Postpay Service Specific Medical Record Review
(Rev. 721; Issued: 06-09-17; Effective: 07-11-17; Implementation: 07-11-17)

Medical record review requires a licensed medical professional to use clinical review judgment to evaluate medical records. Service specific postpay medical record review of claims requires that a benefit category review, statutory exclusion review, and/or reasonable and necessary review be made after claim payment directed at a certain service. This includes requests for, collection and evaluation of medical records or any other documentation. The review is as a result of vulnerabilities determined by data analysis and identified in the Medical Review strategy. If the requested documentation is not received, it is not considered a medical record review. The failure of the provider to submit documentation shall result in a denial. Contractors shall use 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 and Remittance Advice Remark Code (RARC) M127 - Missing patient medical record for this service. For the purpose of calculating and reporting MR workload, cost and savings, this is postpay medical record review and is not to be counted as a probe review.

7.2.2.14 - Data Analysis
(Rev. 444, Issued: 12-14-12, Effective: 04- 01- 13 (FISS and MCS); 07-01-13 (VMS); Implementation: April 1, 2013 (Implementation of FISS and MCS); July 1, 2013 (Implementation of VMS)

Used to identify and verify potential errors to produce the greatest protection for the Medicare program. Data analysis is an essential first step in determining whether patterns of claims submission and payment indicate potential problems. It includes simple identification of aberrancies in billing patterns within a homogeneous group, or much more sophisticated detection of patterns within claims or groups of claims that might suggest improper billing or payment. Data analysis is undertaken as a part of general surveillance and review of submitted claims, conducted in response to information about specific problems stemming from complaints, provider or beneficiary

input, fraud alerts, reports from CMS, other ACs, MACs, or independent government and nongovernmental agencies.

Background	The Contractor uses CERT findings, internal and external data sources, review of claims, and information from other operational areas to identify patterns of erroneous billing submissions and areas of over utilization to target provider-specific review.

7.2.2.15 - Medical Review Edit Development
(Rev. 642, Issued: 02-22-16, Effective: 02-16-16, Implementation: 02-16-16)

Medical Review edit development includes all activities necessary to create and set up a computerized logic test developed with the assistance of health professionals that compares the data elements on a Medicare claim for the purposes of: (1) making a local coverage or coding determination; or (2) suspending a claim so such determinations can be made by appropriate Medical Review personnel prior to or after payment of the claim.

7.2.2.16 - Externally Directed Reviews
(Rev. 10365; Issued: 10-02-20; Effective: 08-27-20; Implementation: 08-27-20)

Medical reviews directed by or directly supporting the OIG, law enforcement, *UPICs*, or court orders, when funded by CMS.

7.2.2.17 - Provider Compliance Group Directed Reviews
(Rev. 642, Issued: 02-22-16, Effective: 02-16-16, Implementation: 02-16-16)

Includes only those Medical reviews and special studies directed by or directly supporting action requested by the Provider Compliance Group (PCG). Contractors shall only count workload under this category as directed or requested by PCG and their COTR.

7.2.2.18 - One on One Education
(Rev. 835; Issued: 10-12-18; Effective: 11-13-18; Implementation: 11-13-18)

This applies to MAC and SMRC.

One-on-one education places emphasis on reducing the paid claims error rate by notifying, either in writing or orally, the individual billing entities (i.e., providers, suppliers, or ordering clinician) of review findings identified on specific claims or a group of claims reviewed on probe or targeted medical review by the MAC, RAC, or SMRC, or based on billing patterns identified by data analysis (e.g., CBRs, OIG reports, PEPPER/FATHOM reports, RAC findings, CERT improper payment findings).
• One-on-one education does not include:
  • Educational articles impacting nationwide issues
  • Responses to inquiries on claims that were not medically reviewed

- General training sessions
- POE education activities
- Speaking at society meetings
- Writing articles in society newsletters regarding new or significantly revised LCDs.

Note: For the purpose of Targeted Probe and Educate (TPE) and TPE specific reporting, letters shall not be considered or reported as one on one education. Please see PIM chapter 3, section 3.2.5 for details regarding the definition of TPE one-on-one education.

7.2.3 - Coding Decisions
(Rev. 444, Issued: 12-14-12, Effective: 04- 01- 13 (FISS and MCS); 07-01-13 (VMS); Implementation: April 1, 2013 (Implementation of FISS and MCS); July 1, 2013 (Implementation of VMS)

Where used in this Chapter, the term "coding decisions" generally refers to MR decisions. For example, coding decisions include each of the following:

- Contractor reviews product information for a durable medical equipment prosthetics, orthotics, and supplies (DMEPOS) item, finds that the wrong code has been billed based upon the review of diagnoses codes and narrative information included on the claim/bill, changes the code to the correct code, and completes the claim.

  In the situation described above, the Contractor denies the claim line with the wrong code and uses the message that the supplier has incorrectly coded the item.

- The Contractor determines that a service billed as a bilateral x-ray is a single view x-ray and indicates a down code to a single view x-ray in the remittance advice.

  Include only coding decisions that require the application of clinical judgment as part of a review, in writing policies, or in the development of guidelines and processing instructions.

7.2.4 - Monthly Reporting of Medical Review Savings
(Rev. 721; Issued: 06-09-17; Effective: 07-11-17; Implementation: 07-11-17)

The Contractor shall utilize the definitions in their statement of work (SOW) to report those savings resulting from medical review. The report shall be submitted by the 20th day of each calendar month and submitted as a deliverable via the CMS ART portal. The activities and metrics to be reported for calculating Medical Review Savings are detailed in the spreadsheet below. The template, developed by the Provider Compliance Group, includes the formulas required to calculate MR savings and shall not be altered or deviated from.

Medical Review Savings Report Template Sample next page.

ACTIVITY	METRIC	SEPT 2016	OCT 2016	NOV 2016	DEC 2016	JAN 2017	FEB 2017	MAR 2017	APR 2017	MAY 2017	JUN 2017	JUL 2017	AUG 2017	SEPT 2017	TOTAL 2017
Monthly Medical Review Reporting for Prepay & Postpay Review Activity-Contractor/MAC #															
Automated MR	# Claims														0
Automated MR	# Claims Denied														0
Automated MR	$'s Denied														$0
Automated MR	$'s Reversed														$0
Automated MR	$'s Saved	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Non-Medical Record Review	# Claims														0
Non-Medical Record Review	# Claims Denied														0
Non-Medical Record Review	$'s Denied														$0
Non-Medical Record Review	$'s Reversed														$0
Non-Medical Record Review	$'s Saved	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Demand Bill Claims MR	# Claims														0
Demand Bill Claims MR	# Claims Denied														0
Demand Bill Claims MR	$'s Denied														$0
Demand Bill Claims MR	$'s Reversed														$0
Demand Bill Claims MR	$'s Saved	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Prepay Provider MRR	# Claims														0
Prepay Provider MRR	# Claims Denied														0
Prepay Provider MRR	$'s Denied														$0
Prepay Provider MRR	$'s Reversed														$0
Prepay Provider MRR	$'s Saved	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Prepay Service MRR	# Claims														0
Prepay Service MRR	# Claims Denied														0
Prepay Service MRR	$'s Denied														$0
Prepay Service MRR	$'s Reversed														$0
Prepay Service MRR	$'s Saved	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Prepay Probe MRR	# Claims														0
Prepay Probe MRR	# Claims Denied														0
Prepay Probe MRR	$'s Denied														$0
Prepay Probe MRR	$'s Reversed														$0
Prepay Probe MRR	$'s Saved	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Postpay Probe MRR	# Claims														0
Postpay Probe MRR	# Claims Denied														0
Postpay Probe MRR	$'s Denied														$0
Postpay Probe MRR	$'s Reversed														$0
Postpay Probe MRR	$'s Saved	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Postpay Provider MRR	# Claims														0
Postpay Provider MRR	# Claims Denied														0
Postpay Provider MRR	$'s Denied														$0
Postpay Provider MRR	$'s Reversed														$0
Postpay Provider MRR	$'s Saved	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Postpay Service MRR	# Claims														0
Postpay Service MRR	# Claims Denied														0
Postpay Service MRR	$'s Denied														$0
Postpay Service MRR	$'s Reversed														$0
Postpay Service MRR	$'s Saved	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
TOTAL	# Claims	0	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	# Claims Denied	0	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	$'s Denied	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
TOTAL	$'s Reversed	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
TOTAL	$'s Saved	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0

(Medical Record Review (MRR))

7.3 - The Strategy Analysis Report (SAR)
(Rev. 599, Issued: 06-26-15, Effective: 12-07-15, Implementation: 12-07-15)

7.3.1 - General Overview
(Rev. 599, Issued: 06-26-15, Effective: 12-07-15, Implementation: 12-07-15)

The purpose of the SAR is to assess progress towards achieving the improvement goals set out by the IPRS. The SAR shall analyze the specific results of the MAC's current IPRS by using a systematic, data-guided evaluation of all aspects of the IPRS:

- the listed prioritized problems
- current changes to the baseline problem measurements specific to each prioritized problem
- progress or lack of progress towards accomplishment of the improvement goals specific to each prioritized problem
- effectiveness of the specific MR activities
- improper payment interventions
- improvement of provider billing behavior

The SAR encapsulates the previous IPRS and uses that information to reassess, modify or to continue with the current planned approach to demonstrate progress towards their stated improvement goals for the current period of performance.

7.3.2 - SAR Required Format
(Rev. 599, Issued: 06-26-15, Effective: 12-07-15, Implementation: 12-07-15)

7.3.2.1 - Cover Page
(Rev. 599, Issued: 06-26-15, Effective: 12-07-15, Implementation: 12-07-15)

The cover page shall include the following information:
- MAC name and address
- MAC contract number
- States in jurisdiction
- Period of performance (explanation shall be included if the SAR is reporting on a period of performance less than 6 months)
- Report coordinator contact information (name, telephone number and e-mail address)
- SAR due date and submission date

7.3.2.2 - Overview/Executive Summary
(Rev. 599, Issued: 06-26-15, Effective: 12-07-15, Implementation: 12-07-15)

The executive summary of the SAR shall provide a brief, high-level summation of overall MR program requirements enacted and any progress, changes, or updates since the submission of the IPRS. This section shall address important projects and CMS requirements that are not captured under the Prioritized Problem List and addressed in the IPRS.

The MAC shall not cut and paste the Overview/Executive Summary from the previous IPRS into the SAR. If there are no changes from information submitted in the previous IPRS, the MAC shall state "no changes from IPRS submitted on x date."

7.3.2.3 - Prioritized Problem List
(Rev. 599, Issued: 06-26-15, Effective: 12-07-15, Implementation: 12-07-15)

The SAR requires the MAC to assess their prioritized IPRS problem list and report on that assessment to date. The SAR shall summarize the MR activities, improper payment interventions, and MR activities taken to address each of the identified prioritized problems in the MAC's IPRS.

This section shall include details on both prioritized problems that were contained in the IPRS, in addition to newly identified problems. Units or measurements used to quantify baseline problem measurements, improvement goals, and the achievement or non-achievement of the improvement goals shall be consistent throughout the SAR and IPRS.

For each specific prioritized problem on the IPRS problem list, the MAC shall provide the following information:

A. Prioritized problem description.

Each prioritized problem on the problem list shall include a problem description. This section shall contain a brief description of problem characteristics and associated planned MR activities and improper payment interventions. The MAC shall include information regarding how the problem was identified (i.e., CERT, Recovery Auditor, CMS, OIG, Comparative Billing Report (CBR), MAC internal data analysis, GAO, etc.)

Duplication of the details contained in the IPRS is not needed; rather, the MAC may refer the reader to the previous IPRS for detailed descriptions, as required. The reader should easily see that the problems already identified and defined in the IPRS correspond to the SAR's listing of numbered problems.

The MAC shall also provide the problem identification number or case number (if used) that is not the ranking number of the prioritized problem. This number shall be consistent in the IPRS and the SAR.

B. Whether the prioritized problem is a new or carry-over problem from the IPRS.

The MAC shall report on both the problems that were identified in the IPRS as well as problems that have been added to the IPRS prioritized list as a result of data analysis. Any prioritized problem removed since the last IPRS shall be explained.

For problems that have been newly identified and added to the SAR subsequent to the IPRS submission, a detailed narrative is appropriate.

7.3.2.4 - MR Activities and Improper Payment Interventions Planning
(Rev. 599, Issued: 06-26-15, Effective: 12-07-15, Implementation: 12-07-15)

The MAC shall provide updates on MR activities and other improper payment interventions planned and/or continued in order to improve the problem and meet

improvement goals. The MAC shall provide updates on the information described in the IPRS. Such information includes, but is not limited to:

- Baseline problem measurement reported in IPRS compared to problem measurement after intervention implementation (may be provider-specific and/or service-specific). The baseline problem measurement from the IPRS and current problem measurement in the SAR shall be the same type of error measurement that was stated in the IPRS.

- Differences in the number of providers and/or services undergoing MR activities and other intervention as reported in the IPRS as what has been observed at the time the SAR is finalized.

- Improvement goal revisions, as appropriate. Effectiveness of the MR activities and improper payment interventions in meeting the goal shall be addressed. These updates shall be stated in measureable terms that are data driven.

- Any identified obstacles regarding the MR activities or improper payment interventions to achieve the improvement goal and suggestions for improvement.

- For each prioritized problem, the contractor shall report on probe reviews conducted, as appropriate. Detailed information shall include:

    o Number of probe reviews identified:
        The number of probe reviews the MAC planned for a specific problem and the type of data and/or analysis used to determine the number of probes.

    o Number of probe reviews initiated:
        A subset of the number identified. This number conveys the actual number of probe reviews effectuated to date. Generally, the probe initiation date is the date a request for medical records is sent to the provider(s). The date of the probe start shall be included.

    o Type of probe review (i.e., pre-pay vs. post-pay, provider-specific vs. service specific)

    o Number of probe reviews completed:
        This number conveys the number of probe reviews concluded. It is the number of probe review cases for which corrective action has been initiated.

    o Probe Results: current problem measurement determined by the probe, progress towards goal, effectiveness of probe edit.

- For each prioritized problem , the contractor shall report on targeted reviews conducted, as appropriate: Detailed information shall include:

  o Number of targeted reviews identified:

    The number of targeted reviews as well as the subject of targeted reviews (benefit, provider type, and provider specific) that the MAC planned for a specific problem, and the type of data and/or analysis used to determine the number.

    In the case of more than one service within a benefit or provider type, the benefit or provider type should be grouped under a general heading in the problem description. However, when reporting the number of identified target reviews planned, the SAR should clearly report the number planned for each code, or range of codes representing the specific service or provider type (Diagnosis Related Group (DRG), Healthcare Common Procedure Coding System (HCPCS), ICD-10) within the benefit or service description. An example is, "Physical Medicine & Rehabilitation: the total number identified for targeted reviews is x number. For physical medicine & rehabilitation CPT code XXX-traction, mechanical, x number of targeted reviews are planned. For physical medicine & rehabilitation code range XXX1-XXX3, therapeutic procedures, x number of targeted reviews are identified (for a total of x number of identified target reviews)." Start date of the targeted review and baseline problem measurement shall be included.

    Similarly, if targeted reviews are planned for specific providers, the total number of providers, the states in which they practice and the service, procedure or diagnosis codes subject to the specific provider targeted claims shall be included in the SAR. An example is, "ESRD, dialysis centers: x number of centers have been identified for targeted reviews. The focus for each dialysis center on targeted review will be XXX CPT Code, extra hemodialysis session. For each center identified, x number of targeted reviews are planned."   The start date and the baseline problem measurement shall be included.

  o Number of targeted reviews initiated:

    This number is a subset of the number described above, "Number Identified". It is the actual number of providers or services activated for targeted review. As described earlier, the SAR shall clearly identify the focus of the targeted review: the procedure, diagnosis or DRG code, or place of service, etc. The percentage of claims to be stopped by an edit for each targeted review shall be included.

- o Type of targeted review (i.e., random v. 100 percent, pre-pay v. post-pay, provider-specific v. service-specific)

- o Number completed:
    This number conveys the number of targeted reviews concluded. It is the number of targeted review cases for which corrective action has been initiated.

- o Targeted Review Results: current problem measurement, progress towards goal, effectiveness of edit.

- Other MR activities and improper payment interventions taken to address the specific prioritized problem and the effectiveness of the interventions.

If analysis of the MR activities and other improper payment interventions shows that the improvement goals have been achieved for a specific prioritized problem, the MAC shall determine if the improved provider billing behavior or decrease in IPR is sustainable. If so, the MAC shall consider closing that problem and/or reprioritizing their problem list.

The MAC shall include a description of the analysis used to make the determination that the improvement goal was met and rationale to support the closing and/or reprioritizing of the problem.

Conversely, if the results of the SAR convey ineffectiveness of the MR activities and improper payment interventions, the SAR shall include modified plans for the areas of ineffectiveness of the IPRS.   The result of this analysis shall lead the MAC to design future MR activities and improper payment interventions aimed at achieving the revised or same improvement goals.

7.3.2.5 - Program Management
(Rev. 599, Issued: 06-26-15, Effective: 12-07-15, Implementation: 12-07-15)

7.3.2.5.1 - Budget and Workload Management
(Rev. 599, Issued: 06-26-15, Effective: 12-07-15, Implementation: 12-07-15)

The SAR shall include a narrative that describes any significant fluctuations in the MR workloads and MR budget since the previous IPRS. The MAC shall include a table identifying any modification made to MR workload since the previous IPRS.

7.3.2.5.1.1 - Workload Reporting Tables
(Rev. 721; Issued: 06-09-17; Effective: 07-11-17; Implementation: 07-11-17)

SAR/Medical Review Program Workload A/B MAC and HHH MAC

SOW	MR Activity	Part A Projected Workload for this Period of Performance	Part B Projected Workload for this Period of Performance	Home Health Projected Workload for this Period of Performance	Hospice Projected Workload for this Period of Performance	Modifications/ Changes since the previous IPRS
C.5.12.1.6	Defending MR Decisions at ALJ Hearings					
C.5.12.2.1	Automated Medical Review					
C.5.12.2.2	Non-Medical Record Review					
C.5.12.2.3	Demand Bill Claims Review					
C.5.12.2.4	Medical Review Reopening					
C.5.12.2.5	Prepay Provider Specific Medical Record Review					
C.5.12.2.6	Prepay Service Specific Medical Record Review					
C.5.12.2.7	Prepay Probe Provider					

SOW	MR Activity	Part A Projected Workload for this Period of Performance	Part B Projected Workload for this Period of Performance	Home Health Projected Workload for this Period of Performance	Hospice Projected Workload for this Period of Performance	Modifications/ Changes since the previous IPRS
	Specific Medical Record Review					
C.5.12.2.8	Prepay Probe Service Specific Medical Record Review					
C5.12.2.10	Postpay Probe Provider Specific Medical Record Review					
C.5.12.2.11	Postpay Probe Service Specific Medical Record Review					
C.5.12.2.12	Postpay Provider Specific Medical Record Review					
C.5.12.2.13	Postpay Service Specific Medical Record Review					
C.5.12.2.17	Externally Directed Reviews					

SOW	MR Activity	Part A Projected Workload for this Period of Performance	Part B Projected Workload for this Period of Performance	Home Health Projected Workload for this Period of Performance	Hospice Projected Workload for this Period of Performance	Modifications/ Changes since the previous IPRS
C.5.12.2.18	Provider Compliance Group Directed Reviews					
C.5.12.2.20	One on One Education					

SAR/Medical Review Program Workload DME MAC

SOW	MR Activity	DME Workload for this Period of Performance	DME Budget for this Period of Performance	Modifications/ Changes Since the Previous IPRS
4.7.1	Automated Medical Review			
4.7.2	Non-Medical Record Review			
4.7.3	Demand Bill Claims Review			
4.7.4	Medical Review Reopening			
4.7.5	Prepay Medical Record Review Provider Specific			
4.7.6	Prepay Medical Record Review Service Specific			
4.7.7	Prepay Medical Record Review Probe Review Provider Specific			
4.7.8	Prepay Medical Record Review Probe Review Service Specific			

SOW	MR Activity	DME Workload for this Period of Performance	DME Budget for this Period of Performance	Modifications/ Changes Since the Previous IPRS
4.7.10	Postpay Medical Record Review Probe Review Provider Specific			
4.7.11	Postpay Medical Record Review Probe Review Service Specific			
4.7.12	Postpay Medical Record Review Provider Specific			
4.7.13	Postpay Medical Record Review Service Specific			
4.7.17	Externally Directed Reviews			
4.7.18	Provider Compliance Group Directed Reviews			
4.7.22	One on One Education			
4.12	Defending MR Decisions at ALJ Hearings			

7.3.2.5.2 - Staffing and Workload Management
(Rev. 599, Issued: 06-26-15, Effective: 12-07-15, Implementation: 12-07-15)

The MACs shall also detail in a narrative any significant fluctuations in staffing or issues with workforce management as appropriate since the previous IPRS.

7.3.3 - Quality Assurance Plan
(Rev. 599, Issued: 06-26-15, Effective: 12-07-15, Implementation: 12-07-15)

The SAR shall include a narrative section titled Quality Assurance (QA) that describes the QA processes actually used since the submission of the previous IPRS. The QA

process information includes, but is not limited to, descriptions for continuous monitoring/surveillance and improvement of the following processes:

- How the MAC monitored the quality of reviews
- Results of the IRR assessments of the MR licensed health care professionals clinical reviewers, and coders from the previous IPRS
- How methods of data analysis were selected, validated and employed
- How edit effectiveness was assessed for each prioritized problem (identify the MAC's threshold for deeming an edit effective; discontinuing an edit)
- How the MAC closely monitored the impact of MR activities and improper payment interventions specific to each problem on the prioritized problem list and their overall improper payment rate
- How the MAC recorded improvement opportunities for their internal use
- How any new processes were introduced to their MR business operations
- Any other information the MAC believes is pertinent to their QA efforts

The narrative information shall not include a restatement from the IPRS; rather, the QA section should be used to communicate the QA processes used since the submission of the previous IPRS as well as those planned for future months. The MAC shall also include an explanation for changes in problem priority, rationale for changes in workload or budget, or new initiatives directed by CMS that required the MAC to suspend activities described in the IPRS.

7.3.4 - SAR Submission
(Rev. 599, Issued: 06-26-15, Effective: 12-07-15, Implementation: 12-07-15)

The MAC shall submit a SAR as directed by the SOW and COR. The current SAR shall be updated or revised as required by the COR after review by the MR, CERT and POE BFLs and the RO TM staff.

7.3.5 - SAR Revision
(Rev. 599, Issued: 06-26-15, Effective: 12-07-15, Implementation: 12-07-15)

The MAC shall notify their COR, RO TM and the MR BFL when their SAR requires a revision/update of the final approved SAR. The revision/update shall be included in the current monthly status report under the A/B MAC Medical Review section, K7 and under the Medical Review section for the DME MACs. The SAR revision shall be noted in the next strategy due deliverable. This deliverable could be either the IPRS or SAR.

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
R10365PI	10/02/2020	Updates to Chapters 1, 2, 3, 4, 5, 6, 7, 8, 10, 11, and Exhibits of Publication (Pub.) 100-08	08/272020	11884
R10228PI	07/27/2020	Updates to Chapters 1, 2, 3, 4, 5, 6, 7, 8, 10, 11, and Exhibits of Publication (Pub.) 100-08 Rescinded and Replaced by Transmittal 10365	08/27/2020	11884
R835PI	10/12/2018	One-on-One Education	11/13/2018	10963
R721PI	06/09/2017	Elimination of Routine Reviews Including Documentation Compliance Reviews and Instituting Three Medical Reviews	07/11/2017	9809
R663PI	07/15/2016	Denial Codes for Missing or Insufficient Documentation	08/16/2016	9690
R642PI	02/22/2016	Medicare Program Integrity Changes - Pub. 100-08 Chapter 7	02/16/2016	9497
R633PI	01/15/2016	Medicare Program Integrity Changes - Pub. 100-08 Chapter 7 – Rescinded and replaced by Transmittal 642	02/16/2016	9497
R607PI	08/12/2015	Workload Reporting	09/03/2015	9215
R600PI	07/02/2015	Workload Reporting – Rescinded and replaced by Transmittal 607	09/03/2015	9215
R599PI	06/26/2015	Annual Improper Payment Reduction Strategy (IPRS)	12/07/2015	9172
R550PI	10/31/2014	One on One Education	12/02/2014	8964
R444PI	12/14/2012	Retirement of the Program Integrity Management Reporting (PIMR) System	04/01/2013	8093
R441PI	11/23/2012	Retirement of the Program Integrity Management Reporting (PIMR) System – Rescinded and replaced by Transmittal 444	04/01/2013	8093
R313PI	11/20/2009	Program Integrity Manual (PIM) Reorganization Chapters 1, 2, and 7	12/21/2009	6546
R237PI	02/01/2008	PIMR Annual Update	03/03/200/	5706
R229PI	11/23/2007	Medical Review Strategy and Strategy Analysis Report	04/07/2008	5760
R220PI	08/24/2007	Various Medical Review Clarifications	09/03/2007	5550
R203PI	05/25/2007	Strategy Analysis Report	07/02/2007	5519
R174PI	11/17/2006	Transition of Medical Review Educational Activities	10/06/2006	5275

Rev #	Issue Date	Subject	Impl Date	CR#
R171PI	11/03/2006	Transition of Medical Review Educational Activities – Replaced by Transmittal 174	10/06/2006	5275
R163PI	09/29/2006	Transition of Medical Review Educational Activities – Replaced by Transmittal 170	10/06/2006	5275
R103PI	02/04/2005	Discontinuation of Medical Review Reports - The Medicare Status Report MRS-1), the Report of Benefit Savings (RBS), the Medicare Focused Medical Review Status Report (MFSR), and the Focused Medical Review (FMR) Report	03/07/2005	3701
R081PI	07/23/2004	Implementation of the Quarterly Strategy Analysis	08/23/2004	3294
R073PI	05/07/2004	Business Requirements for CR3030	06/10/2004	2646
R071PI	04/09/2004	Rewrite of Program Integrity Manual (except Chapter 10) to Apply to PSCs	05/10/2004	3030
R062PI	01/23/2004	Focused Medical Review Report	04/05/2004	3062
R052PI	10/10/2003	FY 2004 Conversion Factors for the Report of Benefit Savings	01/01/2004	2915
R045PI	07/25/2003	FMR Activity Report	08/08/2003	2693
R016PIM	11/28/2001	Adds Various Program Memoranda for BI Requests for Information, Organizational Requirements, Unsolicited Voluntary Refund Checks, Anti-Kickback Statute Implications	11/28/2001	1732
R003PIM	11/22/2000	Complete Replacement of PIM Revision 1.	NA	1292
R001PIM	06/2000	Initial Release of Manual	NA	931

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